

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

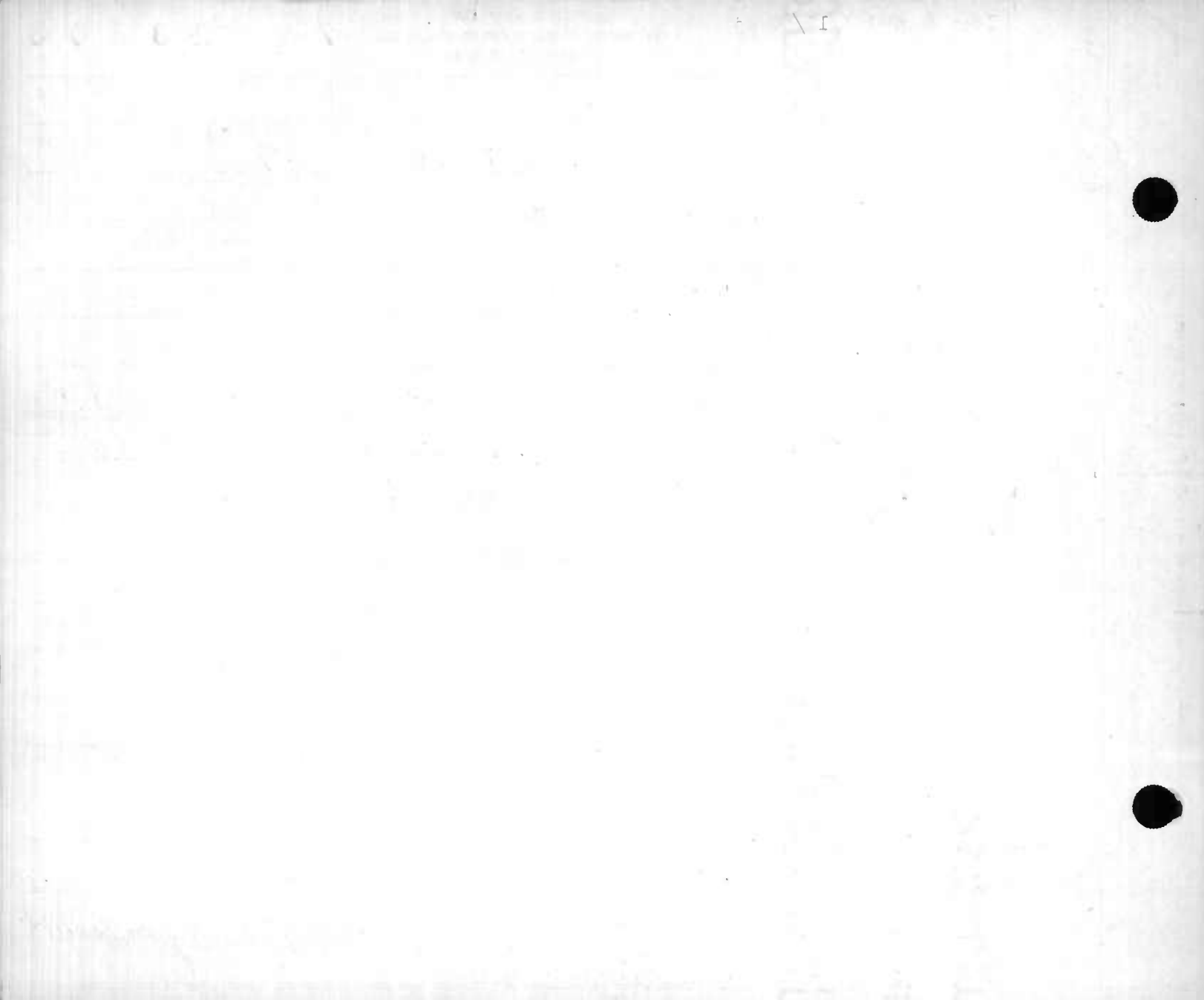
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 8 g541 3/10/80 gj  
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 0 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM H ADAMS			2a. DATE OF DEATH MONTH DAY YEAR 11 15 79			2b. HOUR 6:21 P.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 02 09 20		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Adams SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha L. Robinson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
16b. SOCIAL SECURITY NO. 212-14-3409			17. INFORMANT Teresa Adams -			ADDRESS 114 Frederick Ave Rockville, Md.			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 430- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital saccular aneurysm (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 13 19 79 to Nov 15 19 79, that (I) (we) last saw the deceased alive on Nov 15 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David Satinsky M.D.						DEGREE M.D.		22c. DATE SIGNED 11/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID SATINSKY, M.D.						22e. ADDRESS 5454 Wisconsin Ave, Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (SEE 21)		23b. DATE 11-21-79		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Montgomery Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden						24b. N. Wash. Rockville, Md.		25a. DATE REC'D BY REGISTRAR 11/21/79	



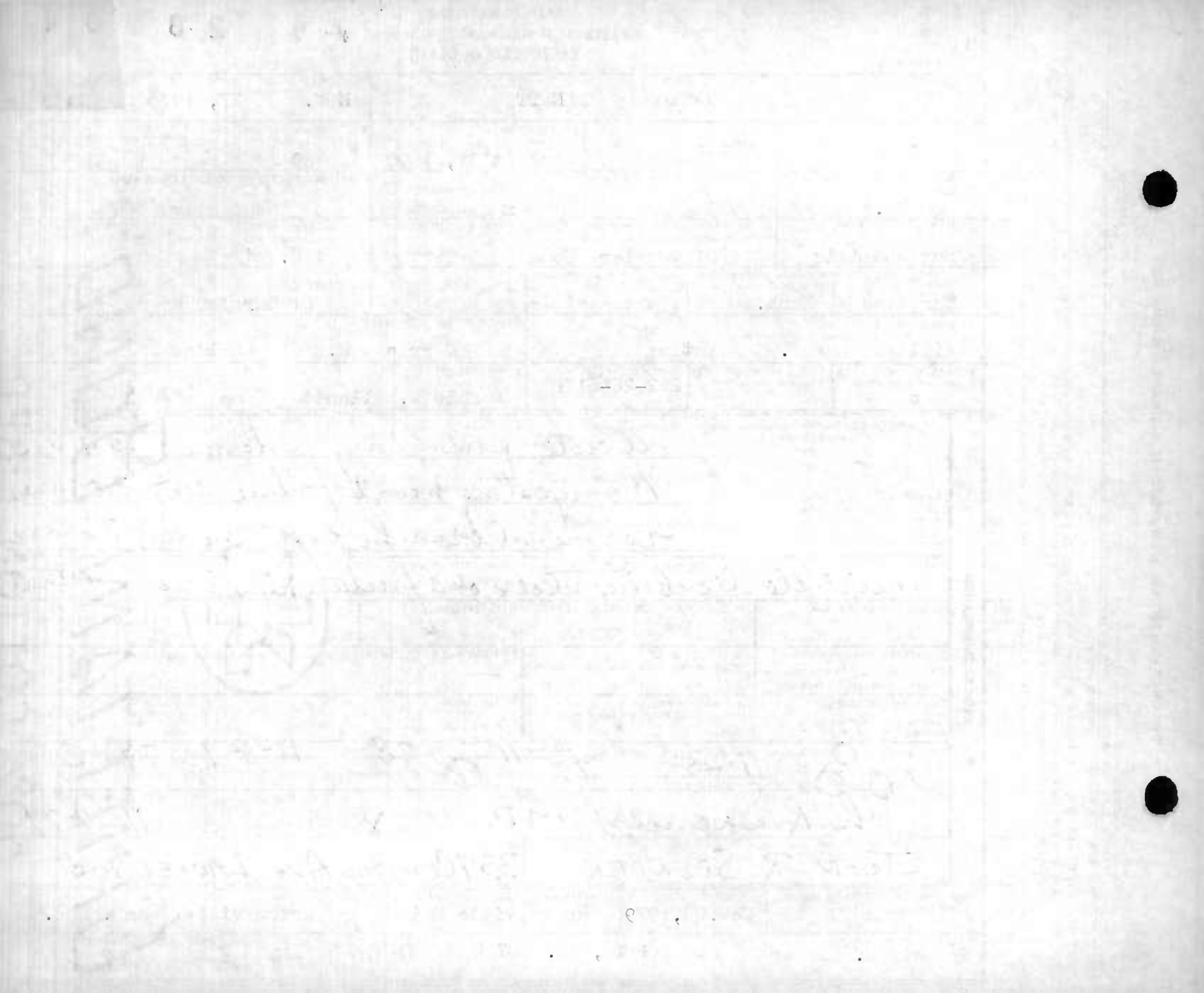
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.		7 9 2 8 3 0 4						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST MARGARET WATERS ALLNUTT			2a. DATE OF DEATH MONTH DAY YEAR NOV. 27, 1979			2b. HOUR A M 1:55 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 31, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Burtonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15701 Oursler Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Burtonsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15701 Oursler Road		
14. FATHER'S NAME FIRST MIDDLE LAST William P. Waters				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie B. Childs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-26-6170		17. INFORMANT ADDRESS Fannie W. Allnutt Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure, acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>terminal bronchopneumonia, acute</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>30 hrs.</u> <u>36 hrs.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>multiple decubitus ulcers, old fracture hips, crippling arthritis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-11-78</u> to <u>11-27-79</u> , that (II) (we) lost saw the deceased alive on <u>11-25-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)										
22b. SIGNATURE <u>John R. Spencer, M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>11-27-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN R. SPENCER</u>				22e. ADDRESS <u>337 Compton Ave, LAUREL, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 29, 1979		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont. Md.				
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760				25. DATE REC'D. BY REGISTRAR DEC 3 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>				





1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Carrie Jenks Austermann</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>8</b> YEAR <b>1979</b>			2b. HOUR <b>11:5</b> P.M.					
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>21</b> YEAR <b>1984</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wilson Health Care Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>201 Russell Ave.</b>			
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b></b> LAST <b>Jenks</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mariaah</b> MIDDLE <b></b> LAST <b>millard</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-20-3990-8</b>		17. INFORMANT <b>Records</b> ADDRESS <b>Gaithersburg, Md.</b> <b>Wilson Health Care</b> <b>201 Russell Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cause Coronary Insufficiency</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Intestinal obstruction, cause undetermined.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs.</b> <b>20 yrs.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (i) (this hospital) attended the deceased from <b>11/8/79</b> to <b>11/8/79</b> that (ii) (we) last saw the deceased alive on <b>11/8/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Henry C. Scovogs MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/9/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HENRY C. SCOVOGS MD</b>				22e. ADDRESS <b>5413 Cedar Lane Bethesda Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Howard Md.</b>			
24. FUNERAL DIRECTOR <b>Gartner-Sandison F. H.</b>				336 E. Diamond Ave. <b>Gaithersburg, Md.</b>				25a. DATE RECEIVED BY REGISTRAR <b>NOV 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Handy</b>	

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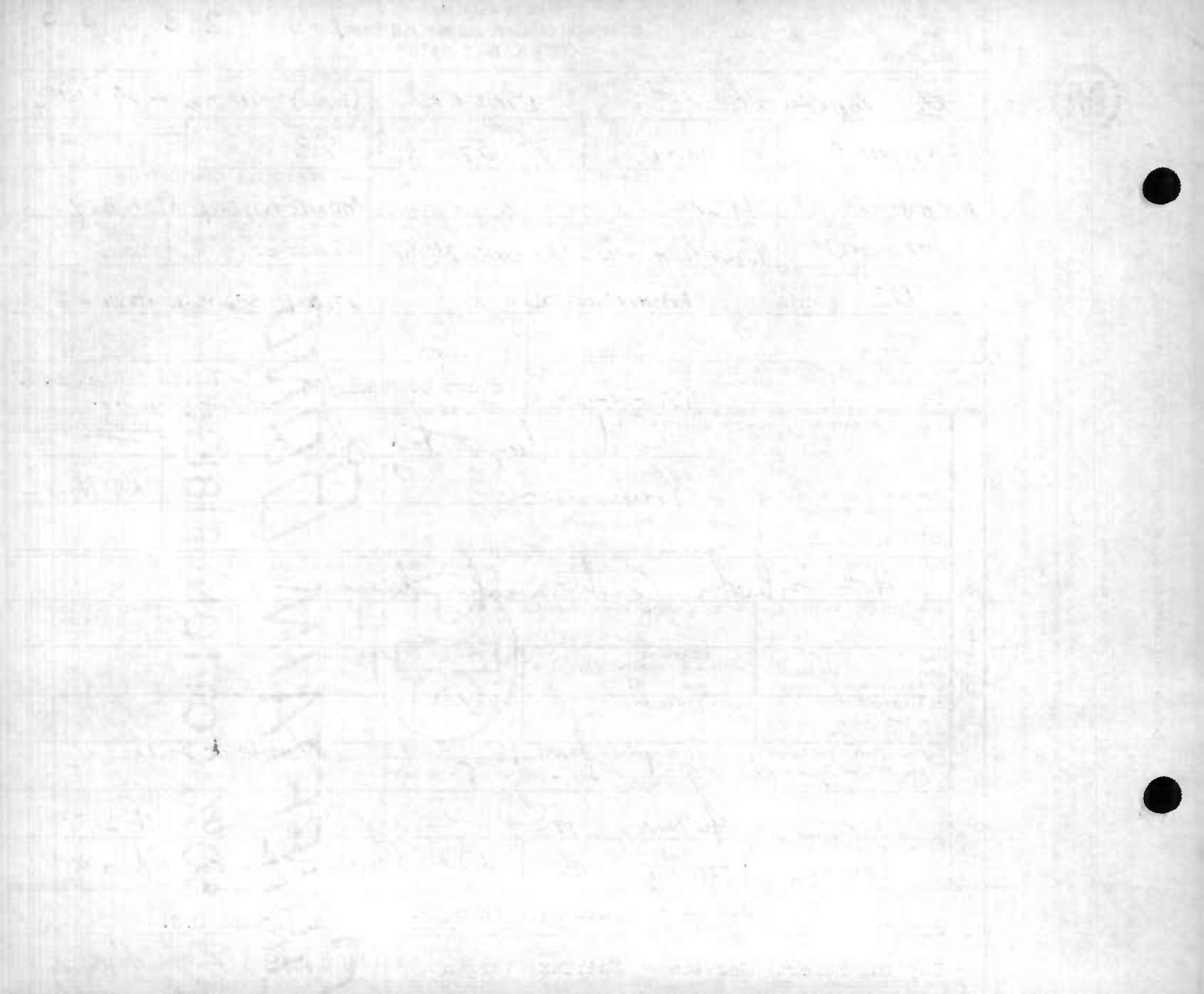
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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGUERITE E. BAKER</b>			2a. DATE OF DEATH MONTH DAY YEAR (Nov.) 11-2-79			2b. HOUR 1:40 A M			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR 7 27 86			6. AGE (IN YEARS LAST BIRTHDAY) 93		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MICHIGAN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD</b>			
10. CITY OR TOWN OF DEATH <b>WILMINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RANDOLPH HILLS NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>DC</b>				13b. COUNTY <b>n/a</b>		13c. CITY OR TOWN <b>WASHINGTON, DC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Cutter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Medlin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-84-4196</b>		17. INFORMANT <b>Robert C. Baker/Son</b>			
				ADDRESS <b>4114 Davis Place, N.W. Washington, D.C.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 10 1978</b> to <b>Nov 2 1979</b> , that (1) (we) lost saw the deceased alive on <b>Nov 1 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Benjamin A. Fennell, MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-2-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Benjamin A. Fennell, MD</b>			22e. ADDRESS <b>3720 Fairview Ave. N.W. Md 20915</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>Nov 2, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Medical School</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service</b>				ADDRESS <b>Fairfax, Virginia</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 06 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	





John

B.

Bollinger

Long.

Washington, Ventist Hospital

11-27-72

11-27-72

11-27-72

11-27-72

11-27-72



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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JESMOND DENE BALMER			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 24, 1979			2b. HOUR 0600 AM											
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 30, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BETHESDA, Mont MD											
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Officer			12b. KIND OF BUSINESS OR INDUSTRY U.S. Army								
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7021 LONGWOOD DR.					
14. FATHER'S NAME FIRST MIDDLE LAST JOHN A. BALMER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE J. ATKINSON			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES 1917-1952						17. INFORMANT J.D. Balmer, Jr. ADDRESS SON, 10325 CROWN PT. CT. POTOMAC, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SUDDEN DEATH FROM COMPLICATING SEVERE</u> <u>4149</u> DUE TO, OR AS A CONSEQUENCE OF <u>ATHERO SCLEROTIC CORONARY</u> <u>ARTERY DISEASE.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that (a) (this hospital) attended the deceased from <u>20 JUNE</u> 19 <u>79</u> to <u>24 NOV</u> 19 <u>79</u> , that (b) (we) last saw the deceased alive on <u>23 NOV</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death.)																	
22a. SIGNATURE Blaine Fitzgerald						22b. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD.			22c. DATE SIGNED 24 NOV 1979								
22a. PHYSICIAN'S NAME (TYPE OR PRINT) BLAINE FITZGERALD M.D.						22b. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/27/1979			23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia								
24. FUNERAL DIRECTOR Oscar A. Gavler's Sons Inc. 5130 Wisconsin Ave., N.W. Wash., D. C.						25a. DATE REC'D. BY REGISTRAR NOV 29 1979							25b. REGISTRAR'S SIGNATURE [Signature]				





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 2 8 3 0 9				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>SIDNEY A. BANKS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-30-1979</b>				2b. HOUR <b>12 16 A M</b>
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>6-20-38</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mo.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. A. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Adventist Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Professor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>University</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>823 Fair Oak Avenue</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Chillum</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Isaac V. Banks, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Arlene D. Watts</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>579-52-1518</b>		17. INFORMANT ADDRESS <b>Judith V. Banks, SAA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Acute Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Atherosclerotic Heart Disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>79</b> to <b>11/29</b> 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>11/29</b> 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.									
22b. SIGNATURE <b>Antonio G. Uy</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/30/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO G. UY</b>					22e. ADDRESS <b>831 Union Blvd E Silver Spring, Md 20903</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Pr. Geo., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>John F. Bell</b> ADDRESS <b>McGuire Funeral Service, Inc. 7400 Ga. Ave. N.W.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John F. Bell</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 1 0			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Alvin T. BARBER				2a DATE OF DEATH November 6 1979		2b HOUR 1220A M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH Oct. 27 1906		6 AGE (IN YEARS LAST BIRTHDAY) 72 73 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b KIND OF BUSINESS OR INDUSTRY Military	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a STREET ADDRESS			
13a STATE D. C.		13b COUNTY Washington		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d 4507 38th Street, N.W.	
14 FATHER'S NAME Horace Y Barber				15 MOTHER'S MAIDEN NAME Mabel M Hartman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WWII 577 01 7750		17 INFORMANT Mrs. Doris E. Barber See item 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e LOCATION STREET CITY OR TOWN COUNTY STATE					
21f WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22a I certify that (I) (this hospital) attended the deceased from Oct. 31 19 79, to Nov. 6 19 79, that I (we) last saw the deceased alive on Nov. 6 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE David R. Range MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 06 NOV 79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID R. RANGE M.D.				22e ADDRESS National Naval Medical Center, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 11/7/79		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION CITY, TOWN, COUNTY, STATE Suitland, Maryland.	
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Washington DC.				25 DATE REC'D. BY REGISTRAR NOV 09 1979		25b REGISTRAR'S SIGNATURE [Signature]	



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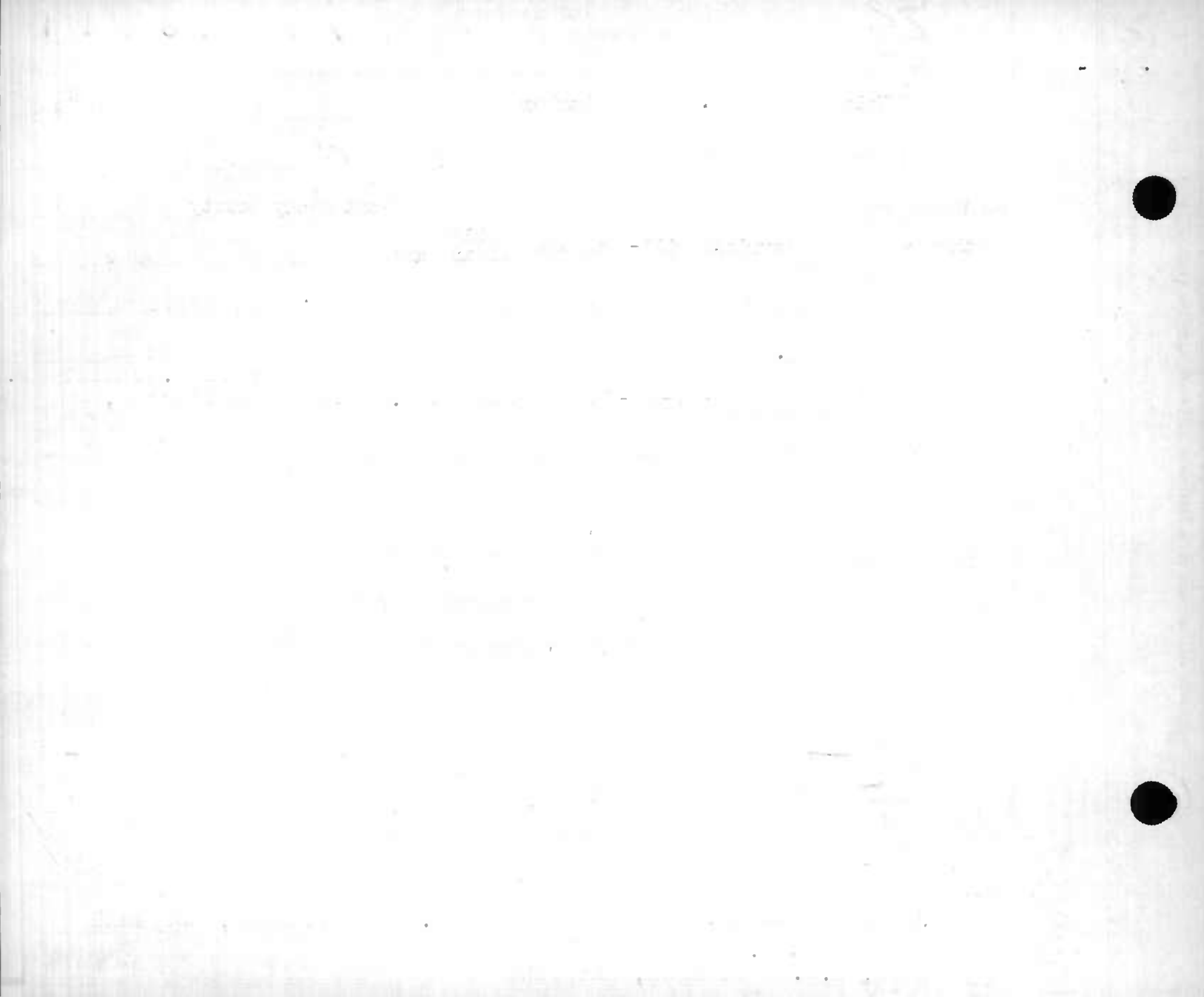
*(Handwritten signature)*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Zola J. Barber					2a. DATE OF DEATH MONTH DAY YEAR 11 29 79				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 26 1884		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS		2b. HOUR 4:50 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill-Bethesda 5215 Cedar Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 8 Woodmoor Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph H. Rest					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Gutman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 217-48-1458		17. INFORMANT ADDRESS 9632 E. Bexhill Dr. Kensington, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): _____									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the physician) attended the deceased from 5/25, 1979, to 11/29, 1979, that (I) (he) lost saw the deceased alive on Nov 8, 1979, and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE James W. Egan M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Nov-29-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EGAN					22e. ADDRESS 5413 Cedar Ln. - Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/1/79		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE Hickory McBrady	

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Freda Mary Jane BARNES					2a. DATE OF DEATH MONTH DAY YEAR November 8 1979			2b. HOUR 2:10P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 29 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? England		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 311 Bradley Avenue		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville					
14. FATHER'S NAME FIRST MIDDLE LAST Edmond Willcocks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Southey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NOX no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Barbara Stehlin		ADDRESS See item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pneumonitis 486- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 29 1979 to Nov. 8 1979, that (I) (we) lost saw the deceased alive on Nov. 8 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>A. R. Cushman</i>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 9, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. R. Cushman, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/10/79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home Rockville, Md.				25a. DATE REC'D. BY REGISTRAR NOV 13 1979		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>			



-- ON XXX





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

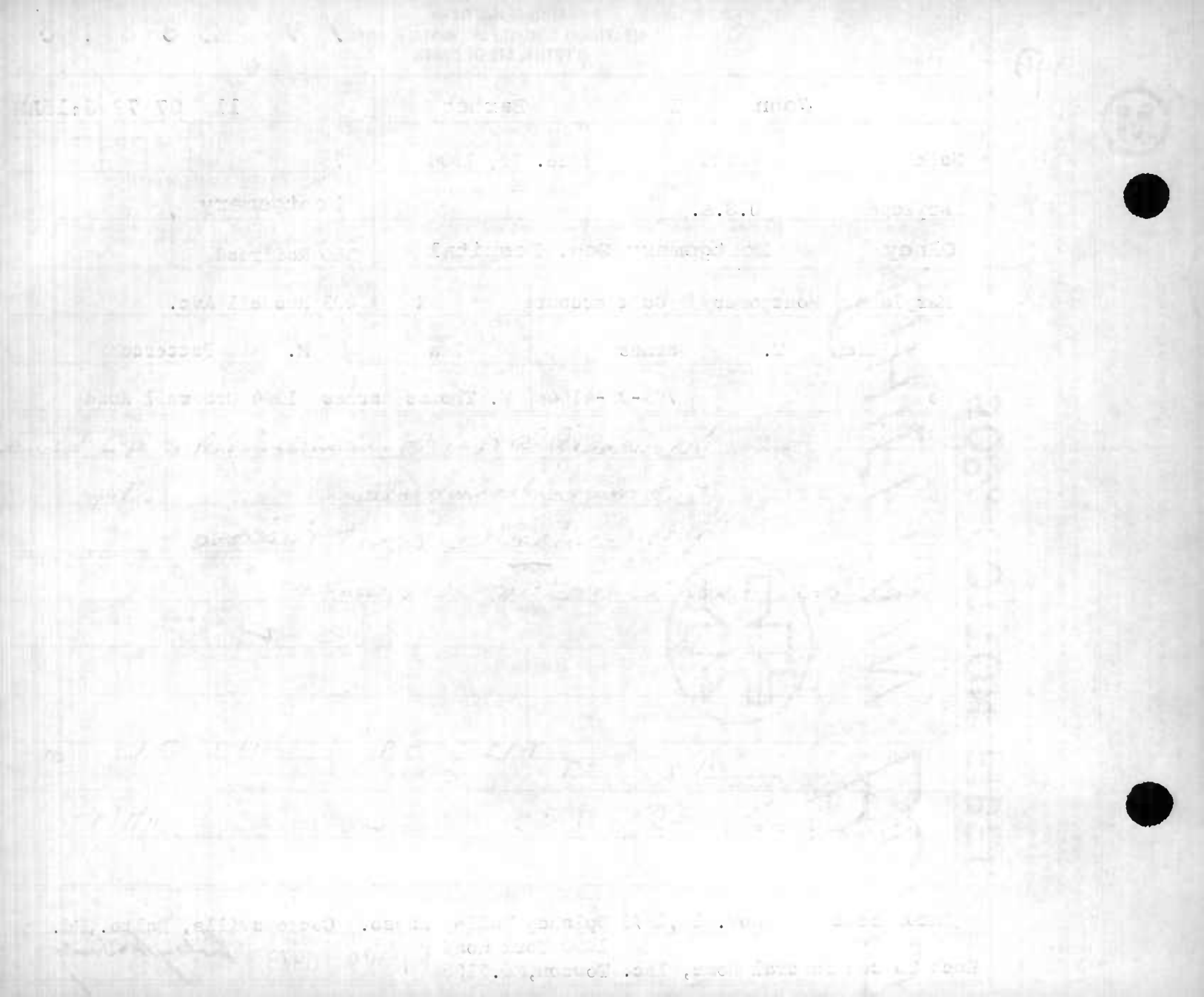
1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>John I Barnes</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11 07 79</b>			2b HOUR <b>6:15AM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Dec. 27, 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD				
10 CITY OR TOWN OF DEATH <b>Olney</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>B&amp;O Railroad</b>		12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>					13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Gaithersburg</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William T. Barnes</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida M. Patterson</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>705-03-4164</b>		17 INFORMANT ADDRESS <b>W. Thomas Barnes 1504 Cranwell Road</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Irreversible acute cardiac failure</b> 410- DUE TO, OR AS A CONSEQUENCE OF <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>42 hours</b> <b>5 days</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH <del>AND</del> RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Pericardial muscle rupture, suspected</b>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <b>11/7</b> 19 <b>79</b> , to <b>11/7</b> 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>11/7</b> 19 <b>79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.										
22b SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11/7/79</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>				22e ADDRESS						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b DATE <b>Nov. 10, 1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>Dylaney Valley Mausoleum</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Balto, Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>				ADDRESS <b>1050 York Road</b>		25a DATE REC'D. BY REGISTRAR <b>NOV 9 1979</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 9 2 8 3 1 4				
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Richard C. Beavers</b>					2a. DATE OF DEATH MONTH <b>11</b> DAY <b>21</b> YEAR <b>79</b>				
3. SEX <b>M</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>5</b> YEAR <b>54</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>23</b> YRS		7b. HOUR <b>8:30 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Montgomery</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10. CITY OR TOWN OF DEATH <b>Beltsville Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Washington Memorial Hosp</b>		12. USUAL OCCUPATION (TYPE OR PRINT) <b>Disabled Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF HUSBAND HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE DEATH) <b>135 Maryland Monty. Beltsville Park</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Beltsville Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>#6-Phila Ave. Beltsville Park</b>	
14. FATHER'S NAME <b>Louis</b>		15. MOTHER'S MAIDEN NAME <b>Gloria B. Blush</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>230-70-6808</b>		17. INFORMANT <b>Mrs. Gloria Beavers (Wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial Endocarditis</b> <b>4249</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Valvular Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yrs.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Gastrointestinal hemorrhage.</b>									
19a. DATE OF OPERATION <b>11/21/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>79</b> , to <b>11/21</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Beverly E. Ludger</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 26-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Natl. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beltsville Park Montgomery Co. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>	
24. FUNERAL DIRECTOR NAME <b>Arthur Walter</b>				24b. ADDRESS <b>254 Carroll St. N.W. Washington, D.C. 20012</b>		25a. REGISTRAR'S SIGNATURE <b>Turkey McBrady</b>		25b. DATE <b>NOV 27 1979</b>	

1701 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 3, RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITALS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Martin S Becker</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11 8 1979</b>	
3 SEX <b>M</b>	4 RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 3 26</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>53</b>	IF UNDER 1 YR. MONTHS DAYS <b>11 8</b>	IF UNDER 24 HRS. HOURS MIN. <b>11 8</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 8 79</b>		2d. HOUR <b>11:12 P.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Judge</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Estate Court</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Silver Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9411 Bruce Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>David ----- Becker</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esther ----- Oscar</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>			16b. SOCIAL SECURITY NO. <b>577-42-2379</b>		17. INFORMANT ADDRESS <b>Etta Becker, 9511 Bruce Dr., Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4291 Asphyxiation</b> Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Chronic myocardial disease (b) <b>Aspiration of vomitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Convulsion</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John Rogers</b>			TITLE (SPECIFY) <b>Day</b>			MEDICAL EXAMINER			DATE SIGNED <b>Oct 7 1979</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John Rogers, M. D.</b>			ADDRESS <b>1919 Seminary Rd. Silver Spring, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11-12-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, P. Geo. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Mem. Chap., Rockville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Pinkney McCreedy</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

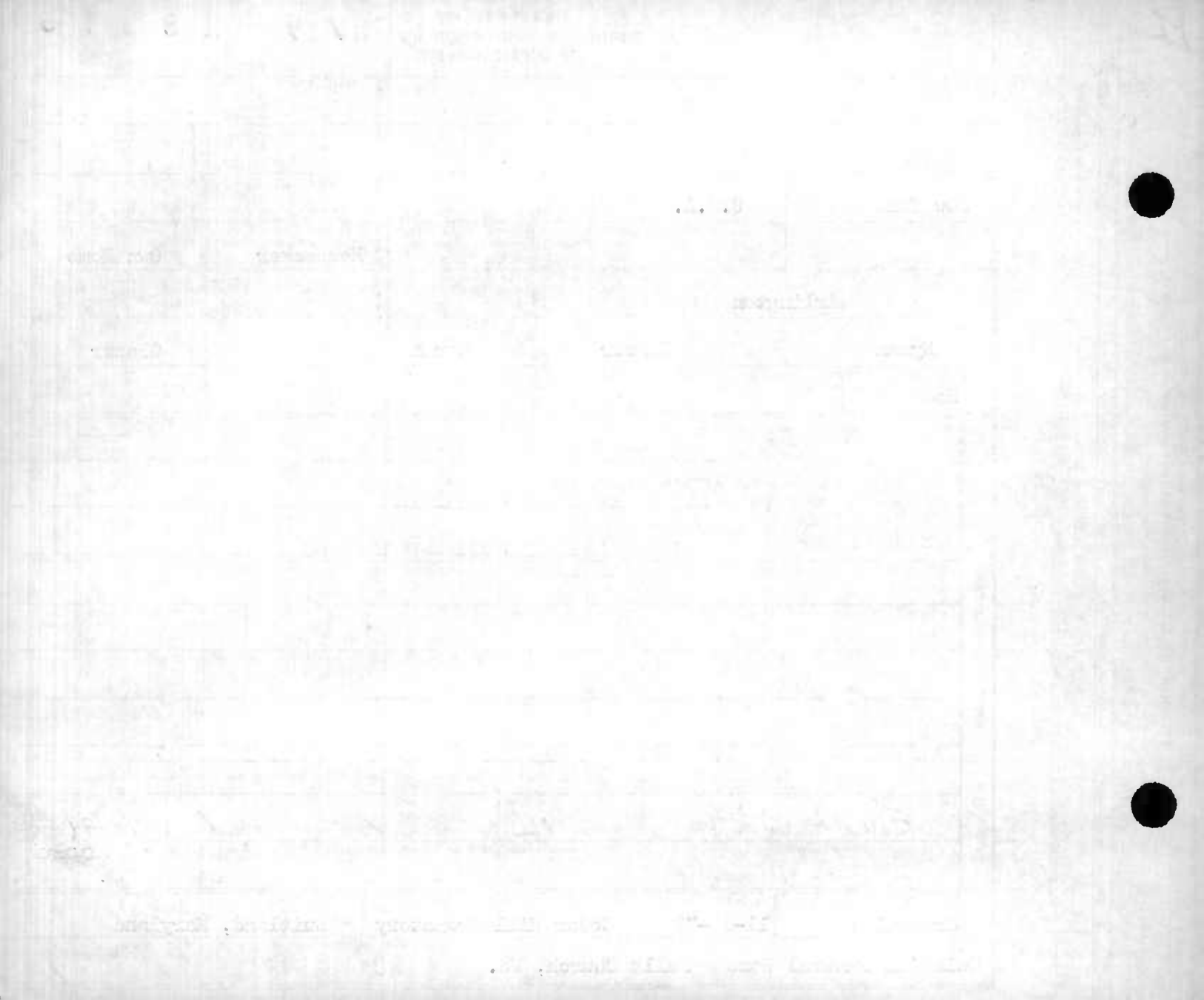
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 8 3 1 6	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH	
Ann B Beckler				November 9, 1979	
3 SEX		4 RACE		5 DATE OF BIRTH	
Female		White		August 3, 1923	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
New York		U.S.A.		56 YRS	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH	
Bethesda		Clinical Center, Bethesda, Md		Montgomery County, MD	
13a STATE		13b COUNTY		13c CITY OR TOWN	
Virginia		Arlington		Arlington, Va	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		1600 South Joyce 22202	
Hyman		Besser		Sarah Glazer	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No		081-18-5418		Mr. Larry Beckler 18 Auburn Ct. #F Alexandria, Va 22305	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>SMALL BOWEL OBSTRUCTION</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>METASTATIC OVARIAN CARCINOMA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (by this hospital) attended the deceased from <u>Sept. 17</u> , 19 <u>79</u> , to <u>Nov. 9</u> , 19 <u>79</u> , that <u>X</u> (we) lost saw the deceased alive on <u>November 9</u> , 19 <u>79</u> , and that <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Eric H. Westin		MD		11/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. Eric H Westin		National Institutes of Health Clinical Center, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		11-10-79		Cedar Hill Crematory	
24 FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Colonial Funeral Home		Falls Church, Va.		NOV 15 1979	
25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Sophie Belkin</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-19-79</b>					2b. HOUR <b>9 A</b> M
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 31, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>S.S.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>N.J.</b>					13b. COUNTY <b>Ocean</b>		13c. CITY OR TOWN <b>Jackson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nikita Bibikoff</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luba Tauber</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>146 58 9644</b>		17. INFORMANT <b>2313 Eccleston St. S.S.Md.</b> <b>Olga Lutchenko (Daughter)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic interstitial pulmonary Scarring</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <b>11/18 19 79</b> to <b>11/19 19 79</b> , that (1) (we) last saw the deceased alive on <b>11/18 19 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)										
22b. SIGNATURE <b>Ralph E. Seligmann</b>				22c. DATE SIGNED <b>11/20/79</b>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RALPH E. SELIGMANN</b>		
22e. ADDRESS <b>8630 Fenton St. Silver Spring, Md 20910</b>				22f. DATE RECORDED BY REGISTRAR <b>NOV 23 1979</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Valadimir Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Jackson Ocean N.J.</b>				
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b>				24b. ADDRESS <b>11800 N.H. Ave. S.S.Md.</b>				25a. DATE RECORDED BY REGISTRAR <b>NOV 23 1979</b>		

MEDICAL CERTIFICATION

34

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this form is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 1 8			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Elwood E. Bell			2a. DATE OF DEATH MONTH DAY YEAR 11 11 79			2b. HOUR 11:40A <sub>M</sub>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 04 13		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY EXXON CORP.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. STREET ADDRESS Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY E. BELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE HOLMES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-05-9891		17. INFORMANT ADDRESS ELSIE G. BELL SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumococcal Meningitis</u> 3501 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 1 day							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>79</u> , to <u>11/13</u> 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>11/11</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)							
22b. SIGNATURE <u>Antonio G. Uy</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. UY		22e. ADDRESS 831 Univ Blvd Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 11/13/79		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR NOV 15 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
500 UNIV. BLVD., W., SILVER SPRING, MD, 20901							





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 1 9			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>MARYANN BELLEVILLE</b>				2a. DATE OF DEATH		2b. HOUR <b>P</b>	
3 SEX <b>Female</b>		4 RACE <b>Cauc.</b>		5 DATE OF BIRTH <b>May 12 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>SUBURBAN</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Mont.</b> 13c. CITY OR TOWN <b>Gaithersburg</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>#5 Redding Ridge Dr.</b>	
14. FATHER'S NAME <b>William Dorten</b>				15. MOTHER'S MAIDEN NAME <b>Amy Lee Waits</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>400-22-2054</b>		17 INFORMANT ADDRESS <b>Richard E. Belleville same as 13e</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4919</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Chronic Bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>years</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> 19 <b>79</b> to <b>4/18</b> 19 <b>79</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. Schulman</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/18</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Toel Schulman</b>				22e. ADDRESS <b>9410 Old Georgetown Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 21, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memo Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lexington, Kentucky</b>	
24 FUNERAL DIRECTOR NAME <b>Robert Sandison</b> ADDRESS <b>Md. 316 E. Diamond Ave. Gaithersburg.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



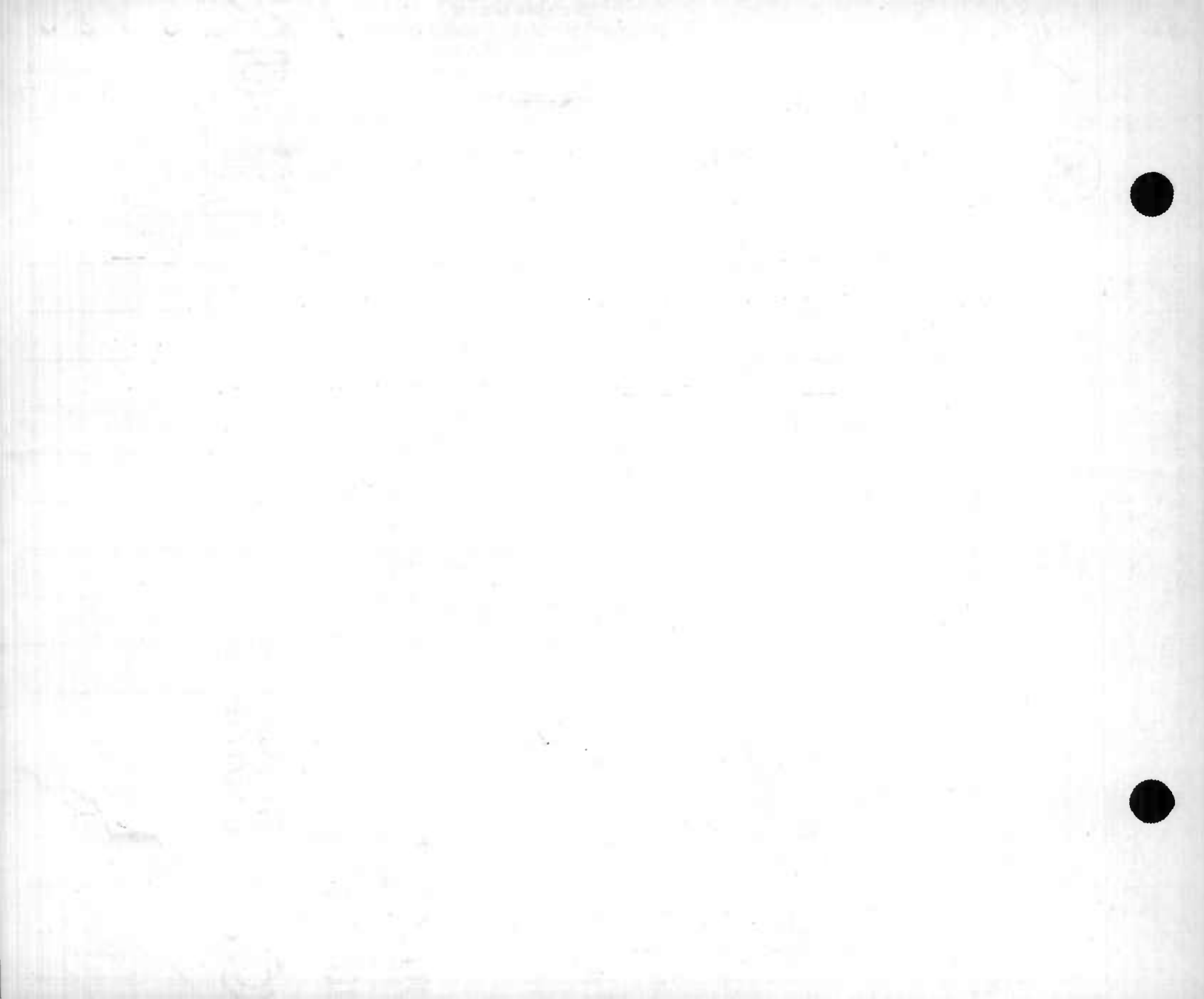
*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 2 0			
FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lena BELLOVIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-16-79</b>		2b. HOUR MIN. <b>7:50</b> <sup>A</sup>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 12 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN <b>Md. Montgomery Kensington</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3000 McComas Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Shannon unkn.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etta Dworkin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>055-01-2925</b>		17. INFORMANT ADDRESS <b>Stella Bellovin 6534 Fairlawn Dr. McLean, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute &amp; Subacute peritonitis secondary to</b> <b>5579</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Perforated peptic ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>---</b>							
19a. DATE OF OPERATION <b>10/7/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated peptic ulcer</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> 19 <b>79</b> , to <b>11/16</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/15</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>---</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/16/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. EICHLER</b>				22e. ADDRESS <b>911 S. 516. Ave S. 516, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 18, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth David,</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elmont Queens N.Y.</b>	
24. FUNERAL DIRECTOR <b>Danzansky-Goldberg Inc. Rockville Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIAHU BENAIM			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 1, 1979			2b. HOUR 8:30 P.M.			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 11 1931		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MOROCCO		7b. CITIZEN OF WHAT COUNTRY? ISRAEL		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2445 LYTTONSVILLE ROAD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BEAUTICIAN		12b. KIND OF BUSINESS OR INDUSTRY BEAUTY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS APARTMENT 707 2445 LYTTONSVILLE ROAD									
14. FATHER'S NAME FIRST MIDDLE LAST NESSIM BENAIM			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FREHA ZAZOUN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-84-3608		17. INFORMANT EDMOND BENAIM			ADDRESS SAME AS # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic cancer of colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION 10/2/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA of colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>9/18/78</u> to <u>11/1/79</u> , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <u>11/1/79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <input type="checkbox"/> did not see the body after death.							
22b. SIGNATURE <u>David A. Morawitz</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/2/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID A. MORAWITZ, MD				22e. ADDRESS 106 IRVING ST. N.W. D.C.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 11/2/1979		23c. NAME OF CEMETERY OR CREMATORY SHOMREI HADAS FUNERAL HOME BROOKLYN, NEW YORK		23d. LOCATION 4519 FT. HAMILTON PARKWAY	
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL F.H.				25a. DATE REC'D. BY REGISTRAR NOV 05 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>	
232 CARROLL STREET, N. W. WASHINGTON D. C.							

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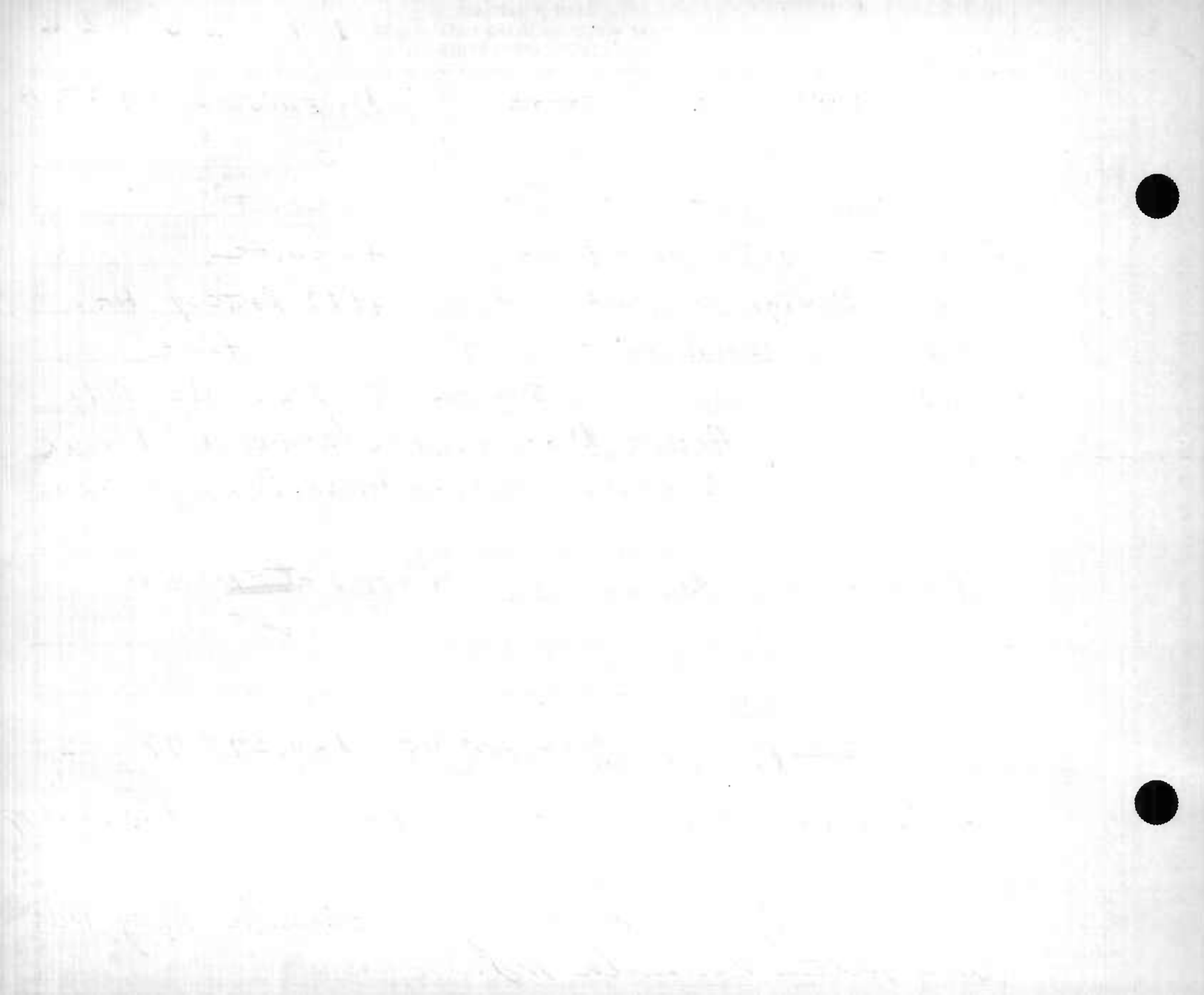
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 3 2 2	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST: Corrine C. MIDDLE: LAST: Bennett					2a. DATE OF DEATH MONTH: NOVEMBER DAY: 27 YEAR: 1999			2b. HOUR 12:30 AM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH: 4 DAY: 25 YEAR: 06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4977 BATTERY LA.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. 13b. COUNTY: MONTG. 13c. CITY OR TOWN: Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4977 BATTERY LA.				
14. FATHER'S NAME FIRST: W. M. MIDDLE: WALDHUTER LAST: T.					15. MOTHER'S MAIDEN NAME FIRST: T. MIDDLE: HOINE LAST: T.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS: JOHN BENNETT Beallsville Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF: (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF: (c) 1 YEAR APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): DIABETES MELLITUS HYPERTENSION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 19 78 to NOV. 27 19 79, that (I) (we) last saw the deceased alive on NOV. 27 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur Bruggeman, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Nov 28, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/30/79		23c. NAME OF CEMETERY OR CREMATORY Moniacy		23d. LOCATION CITY OR TOWN: Beallsville COUNTY: MONTG. STATE: Md.					
24. FUNERAL DIRECTOR NAME: W. C. Hilt ADDRESS: Beallsville Md.					25a. DATE REC'D. BY REGISTRAR DEC 7 1979		25b. REGISTRAR'S SIGNATURE Richard A. Brady				





Items 15, 16 g538 12/6/79 g3

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28323

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
John		Thomas		Bennick				11-14-79		8:50AM							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	June 7 1968		68 YRS.						11-14-79		8:50AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
PENNSYLVANIA		U.S.A.				Mont.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
72k Bk		Washington Adventist Hospital		INSPECTOR WTS & MEASURES/ GOVT.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. ADDRESS									
Md		Mont		72k Bk		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		214 Philadelphia Ave									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
THOMAS		AGNES		YES		189-05-5732		ADA T. BENNICK		SAME AS 13		WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4291		Acute myocardial Dis.		(b)		Chronic myocardial Dis.		4yr.									
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED									
JOHN S. ROGERS		1919 SEMINARY ROAD, SILVER SPRING, MD.						11/17/79									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
BURIAL		11/17/79		CEDAR HILL CEMETERY		SUITLAND		PRI GEO		MD.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
FRANCIS J. COLLINS		NOV 15 1979		F. J. Collins													
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 2 4

1. FOR STATE REGISTRAR			REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL E. V. BERGER			2a. DATE OF DEATH MONTH DAY YEAR 11-27-1979	
3. SEX MALE			2b. HOUR 6 <sup>28</sup> PM	
4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1-12-97		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? XXXXXXXXXX USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) XXXXXXXXXX WASHINGTON ADVENTIST HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SYSTEM ANALYST		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN TAKOMA PARK		13c. STREET ADDRESS 7807 XXXXXXXXXXXX COLE AVE.
14. FATHER'S NAME FIRST MIDDLE LAST Charles T. Berger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victorine Lagesser		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-44-3923		17. INFORMANT ADDRESS CECILE BERGER SAME AS 13 WIFE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe peripheral vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Coronary Artery Disease</u> 4140				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): COPD s/p metastatic				
19a. DATE OF OPERATION 11/21/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH & urinary retention		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.				
22b. SIGNATURE Mark Andrews MD		DEGREE MD		22c. DATE SIGNED 11/27/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Andrews MD		22e. ADDRESS 7800 McCarroll Ave		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/30/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		23e. DATE REC'D BY REGISTRAR DEC 3 1979		23f. REGISTRAR'S SIGNATURE [Signature]
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				
500 UNIV. BLVD., W. SILVER SPRING, MD, 20901				



*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

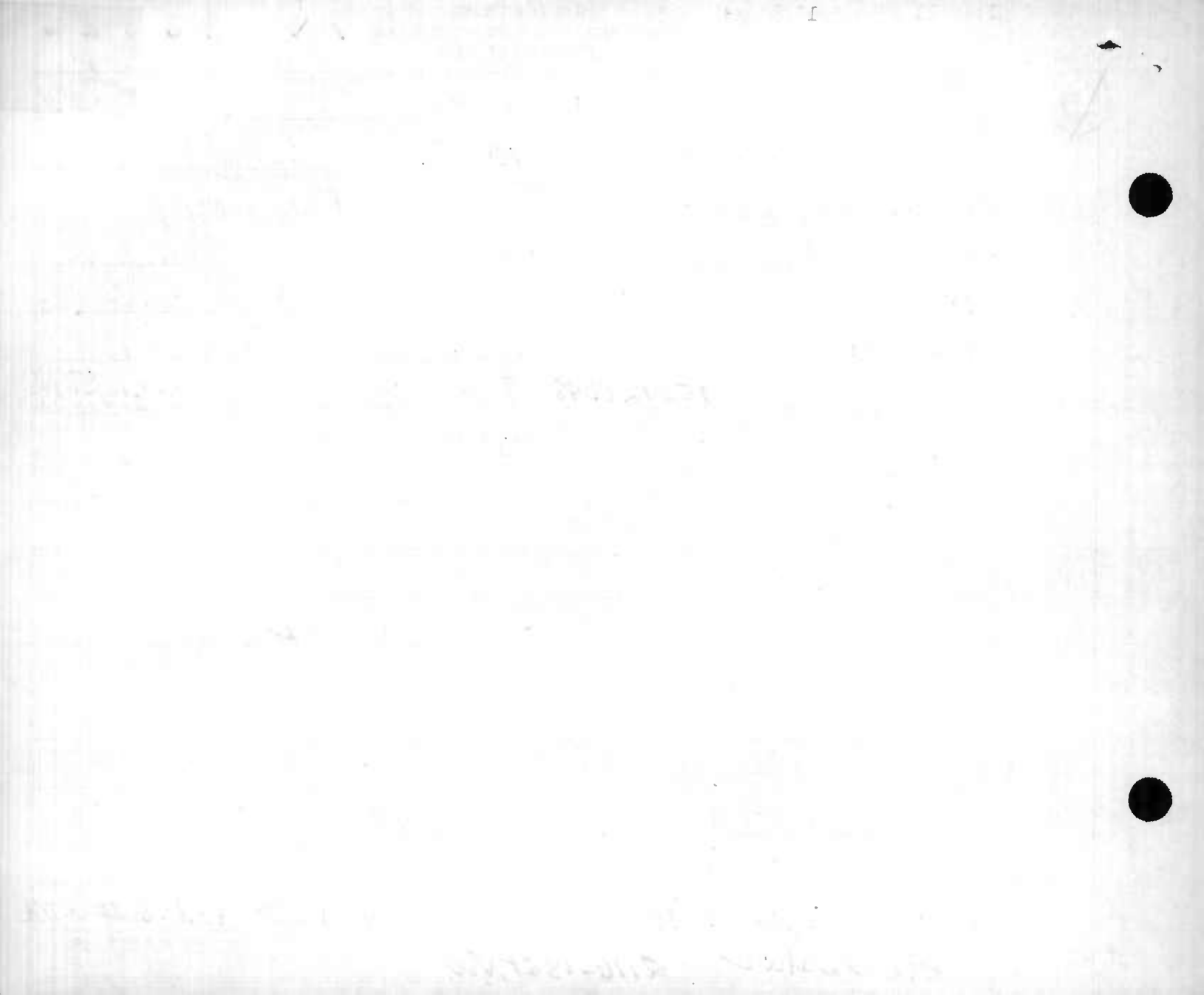
*[Handwritten signature or initials in the bottom left corner.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 11 8541 3/22/80 83 FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9		2 8 3 2 5	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beatrice Berryman										2a. DATE OF DEATH MONTH DAY YEAR 11-21-79				2b. HOUR 12 PM									
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 1-10-13			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 66 YRS			7. IF UNDER 1 YEAR IF UNDER 24 HRS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carytown NC			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.														
10. CITY OR TOWN OF DEATH Silver Spring Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE			12b. KIND OF BUSINESS OR INDUSTRY NONE										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN M.D. Mont.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8860-Piney Branch Rd											
14. FATHER'S NAME FIRST MIDDLE LAST DAVID Foushee					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA Gordon																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO 152-12-0048					17. INFORMANT ADDRESS O.T. Foushee - 709-Magnolia St. NC													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 1389 DUE TO, OR AS A CONSEQUENCE OF Shock (b) 2 days DUE TO, OR AS A CONSEQUENCE OF Sepsis (c) 2 days												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): massive Obesity																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (1) (this hospital) attended the deceased from 11-20-79 to 11-21-79, that (1) (we) last saw the deceased alive on 11/21/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE John L Ford MD								DEGREE		22c. DATE SIGNED 11/21/79													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN L FORD MD								22e. ADDRESS 394 University Blvd W Silver Spring Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov 26-79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE 4001-Suitland Rd - Suitland Md													
24. FUNERAL DIRECTOR NAME AB Fisher				ADDRESS 2116-18th NW				25a. DATE REC'D. BY REGISTRAR NOV 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]													





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Floyd J. BERTOGLIO			2a. DATE OF DEATH MONTH DAY YEAR November 19 1979		2b. HOUR 5:20A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Apr. 29 1918	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Virginia	13b. COUNTY Fairfax	13c. CITY OR TOWN Fairfax	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10216 Raider Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Bertoglio		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Mayernick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1941-69	17. INFORMANT ADDRESS Mrs. Marguerite Bertoglio See Item 13		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Melanoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 8</u> 19 <u>79</u> , to <u>Nov. 19</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE <i>Jeffrey M. Crane</i>	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED Nov. 19 1979
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey M. Crane, M.D.		22e. ADDRESS National Naval Medical Center, Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov 21, 1979	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.
24. FUNERAL DIRECTOR NAME Everly Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 21 1979	25b. REGISTRAR'S SIGNATURE <i>Jeffrey M. Crane</i>

U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C.

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

*Wm. H. L.*

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Genevieve L. Billhimer</b>			2a. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>79</b>			2b. HOUR <b>6: P M</b>					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>4/19/88</b>		6. AGE (In years last birthday) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3600 Gleagles Dr.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>No</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3600 Gleagles Dr.</b>		
14. FATHER'S NAME First <b>James</b> Middle <b>T.</b> Last <b>Luckett</b>			15. MOTHER'S MAIDEN NAME First <b>Lucie</b> Middle <b>Peyton</b> Last <b>Peyton</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>220-44-3892</b>		17. INFORMANT (daughter) <b>Genevieve L. Cromwell-Rd.,</b>			Address <b>1180 Cavalier, Arnold, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auto Extensive rt. Hemiparesis Thromboses</b> <b>4340</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes mellitus, Severe cerebral atrophy.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/14/1977</b> , to <b>11/12/79</b> , that (I) (we) last saw the deceased alive on <b>8 Nov 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gustavo S. Belaval MD</b>						DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>14 Nov 79</b>		
22d. PHYSICIAN'S NAME (Type) <b>GUSTAVO S. BELAVAL</b>						22e. ADDRESS <b>Leisure World Medical Center - Silver Spring Md 20906</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>11-15-1979</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Brentwood Pr. Georges Md</b>		
24. FUNERAL DIRECTOR <b>James E. Pumphrey, Inc.,</b>			ADDRESS <b>8434 Ga. Ave.,</b>			25a. REC'D BY REGISTRAR <b>NOV 16 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Notary Public</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



*[Faint, mostly illegible text covering the majority of the page, appearing to be a letter or document.]*

*[Faint signature or text at the bottom center of the page.]*

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Kenneth Bitzel						2a. DATE OF DEATH MONTH DAY YEAR November 2, 1979			2b. HOUR 2:20		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1930		6 AGE (IN YEARS LAST BIRTHDAY) 48 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center (NIH)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Draftsman		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse			
13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William David Bitzel						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Schaefer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17 INFORMANT Mrs. Joyce Bitzel (wife)		ADDRESS (same as above)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 2028 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Renal Failure</u> (c) <u>Progressive Lymphoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 26,</u> 19 <u>79</u> , to <u>Nov. 2,</u> 19 <u>79</u> , that (I/we) last saw the deceased alive on <u>Nov. 2,</u> 19 <u>79</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did <input checked="" type="checkbox"/> not view the body after death.											
22b. SIGNATURE <i>Max Wicha</i>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/2/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX WICHA				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md, 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/2/79		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balt., Md.					
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home						ADDRESS Catonsville, Md.		25a. DATE REC'D. BY REGISTRAR NOV 6 1979		25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>	

MEDICAL CERTIFICATION

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

1911



1911

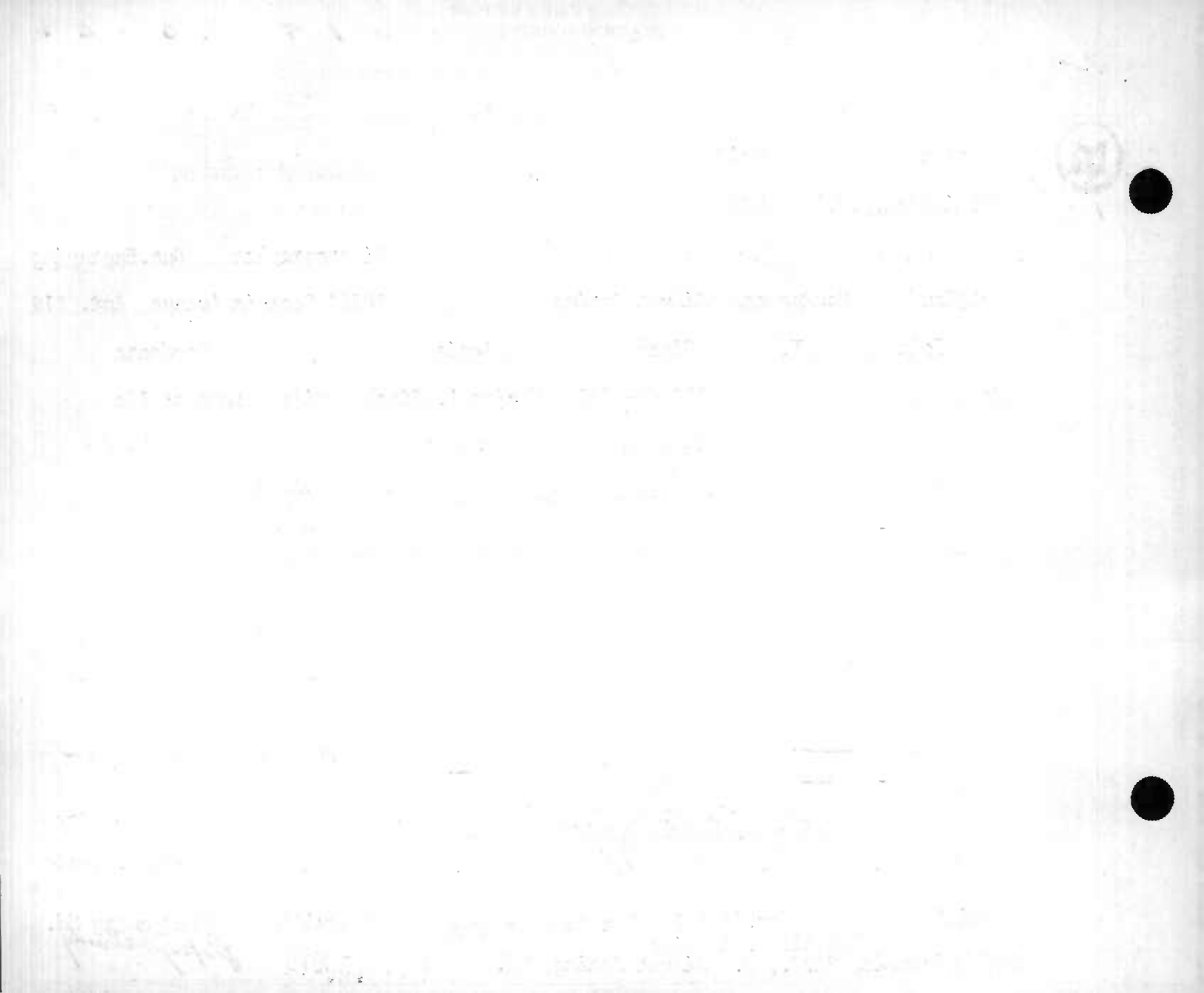
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						7 9 2 8 3 2 9					
FOR STATE REGISTRAR						REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Andrew			Black			11-9-79			12:23 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2+ HRS	
male		white		4 08 00		79 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Siderographer		Bur. Engraving			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		10820 Georgia Avenue Apt. 210			
Maryland		Montgomery		Silver Spring							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John T. Black				Annie Goodacre							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
No				213-42-9565		Thelma L. Black wife same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 496- Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b). Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the deceased) attended the deceased from 10/25, 1979, to 11/9, 1979, that (I) saw the deceased alive on 11/9, 1979, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
WALTER E. GOOZH MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/9/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
WALTER E. GOOZH MD						8209 SHOREFIELD RD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			Nov. 12, 1979		Parklawn Cemetery		Rockville Montgomery Md.				
24. FUNERAL DIRECTOR NAME						24b. DATE REC'D. BY REGISTRAR		25b. REG. STAMP SIGNATURE			
Francis J. Collins 500 University Blvd., W. Silver Spring, Md.						NOV 15 1979					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 3 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Mary W. Blackburn			2a DATE OF DEATH MONTH DAY YEAR Nov. 28th. 1979			2b HOUR 6:10 P.M.				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 23, 1890			6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland				13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas W. Whitlow				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Salenia Unknown						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-03-6217D		17 INFORMANT P. O. Box 4334 Marian Humphrey Silver Spring, Md. 20904				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from 3/11 19 78, to 11/28 19 79, that (1) (we) lost saw the deceased alive on 11/28 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b SIGNATURE Myron L. Lenkin DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 11/28/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN						22e ADDRESS 2309 SHOREFIELD RD. WHEATON MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Dec. 1, 79		23c NAME OF CEMETERY OR CREMATORY National Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Falls Church, Fairfax, Va.			
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home						25a DATE REC'D. BY REGISTRAR DECO 3 1979		25b REGISTRAR'S SIGNATURE Anthony McCready		
11800 New Hampshire Ave. Silver Spring, Md										

U.S. GOVERNMENT PRINTING OFFICE

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### MEDICAL CERTIFICATION

DHMH-17  
(VR A15 ME (5))  
30M 7/73

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. GIVE PAGE 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 3 2

FOR  
STATE  
REGISTRAR

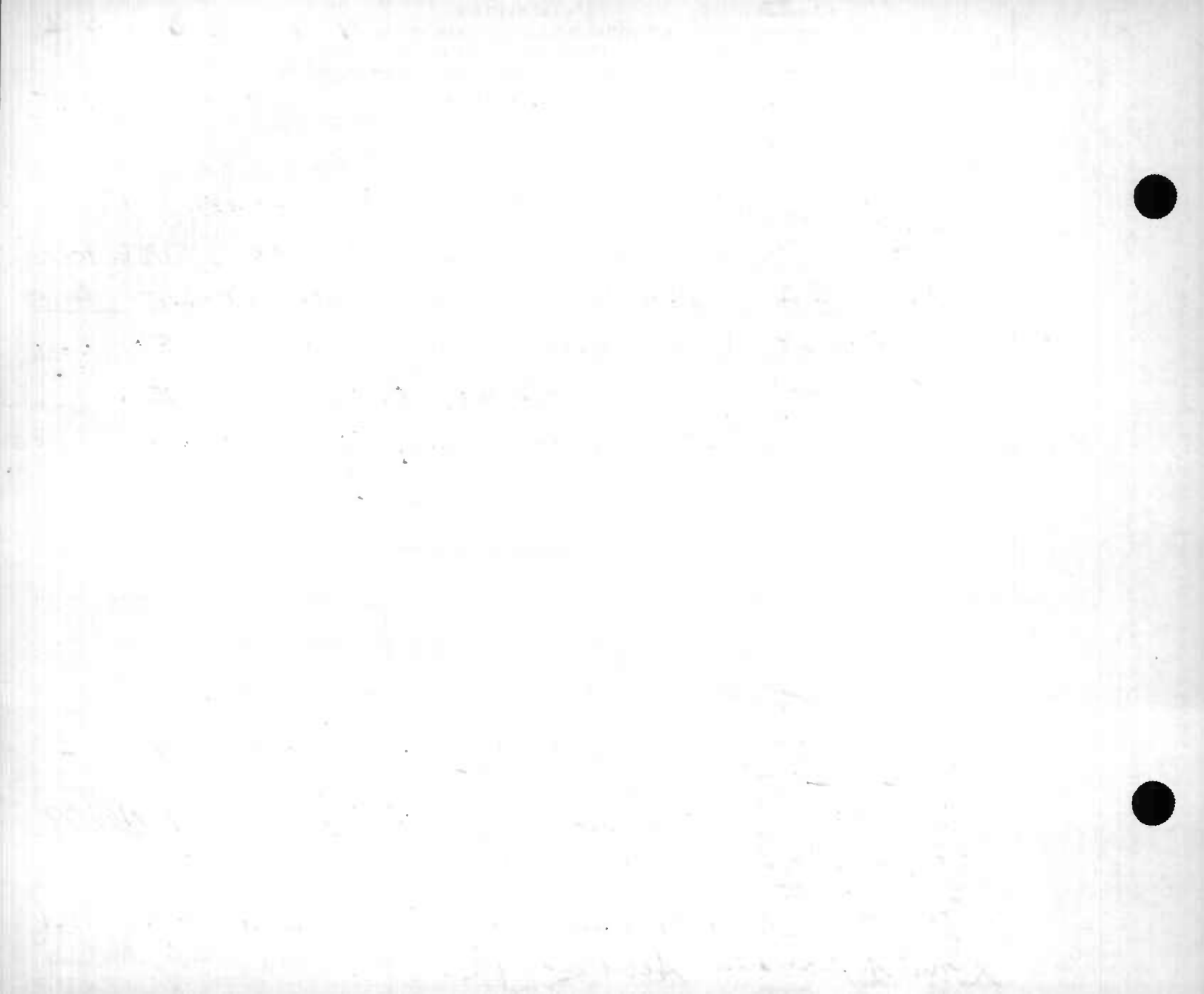
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ADNA R. BOND</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 15 79</b>		2b. HOUR <b>4 12 P.M.</b>	
3. SEX <b>M</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8-5-16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE CONVAL.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DIRECTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE FOREST</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>ARNOLD</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE ROSS BOND</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINERVA SNYDER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>JENNEY BOND - ABOUTE</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>WALDEN STROM'S MACROGLOBULINEMIA</b> <b>2733</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) <del>viewed</del> <b>viewed</b> the deceased from <b>12 NOV 1979</b> , to <b>15 NOV 1979</b> , that (I) <del>lost</del> <b>lost</b> saw the deceased alive on <b>14 NOV 1979</b> , and that in (my) <del>own</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do not</del> <b>do not</b> view the body after death.			
22b. SIGNATURE <b>Walter E. Goetz</b>		22c. DATE SIGNED <b>15 NOV 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER E. GOETZ MD</b>		22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON MD</b>	

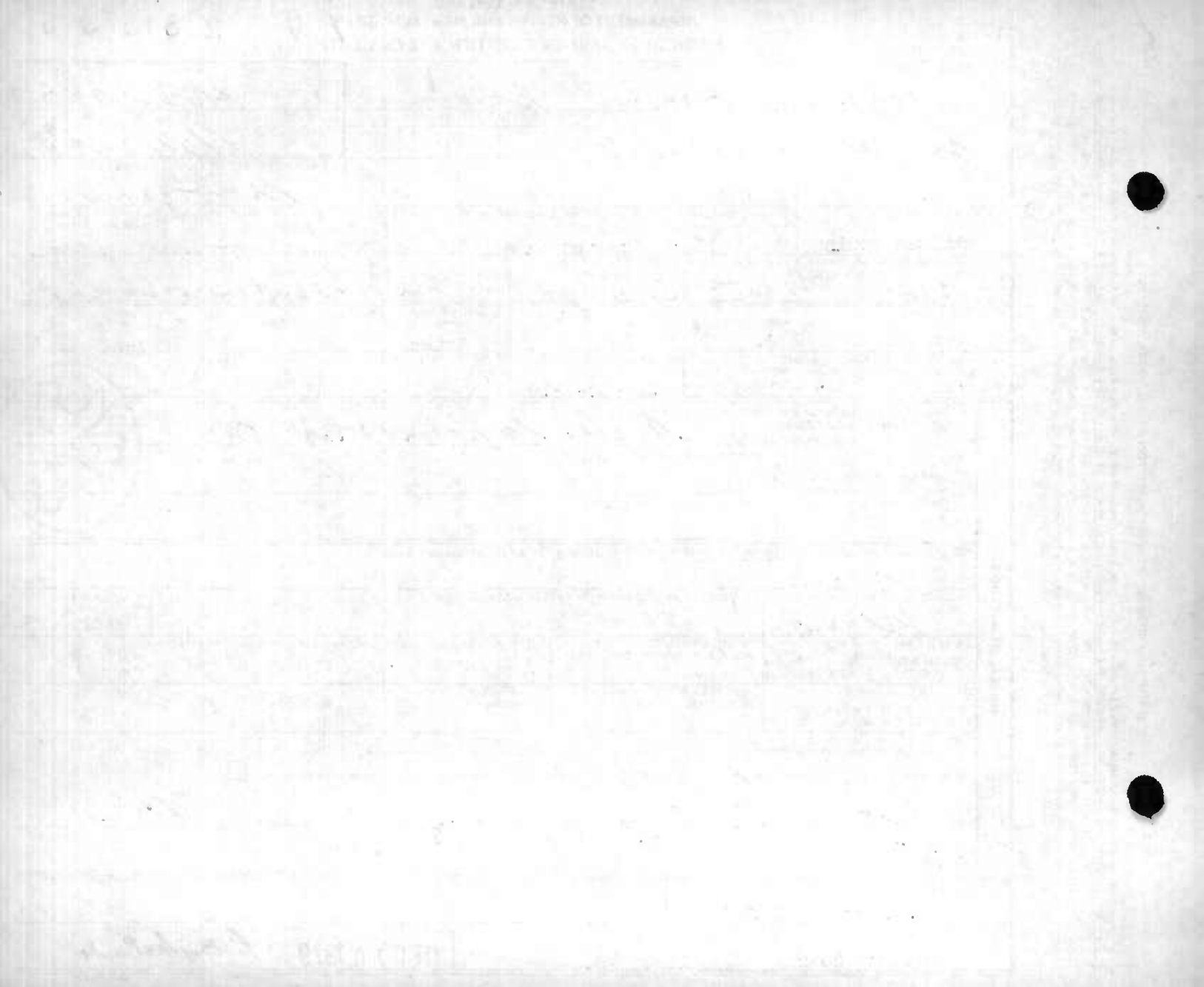
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>	23b. DATE <b>11-19-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury U. Meth.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arnold AA MD</b>
24. FUNERAL DIRECTOR NAME <b>Shirley A. Romano</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Shirley A. Romano</b>





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										9 2 8 3 3 3	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI-MATED		2b. HOUR	
William		Hanson		Bowen				Nov 27, 1979		AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	June 26, 38		49 YRS.				Nov 30, 1979		PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		11452 Stewart Lane						Computer Program.		Fed. Govt.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Md.		Mont.		Sil. Spg						11452 Stewart Lane APT-1	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Bernice P.		Agnes		Yes		1948 - 1951		Ching			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4291		Acute Myocardial Dis.									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF							
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)						DATE SIGNED			
John P. Rogers, M.D.		MEDICAL EXAMINER						Nov. 30, 1979			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Removal		12/1/79									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Anatomy Board		Balto., Md.		DEC 10 1979		R. J. K. Brady					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

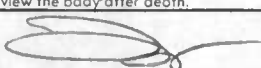
DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 3 4

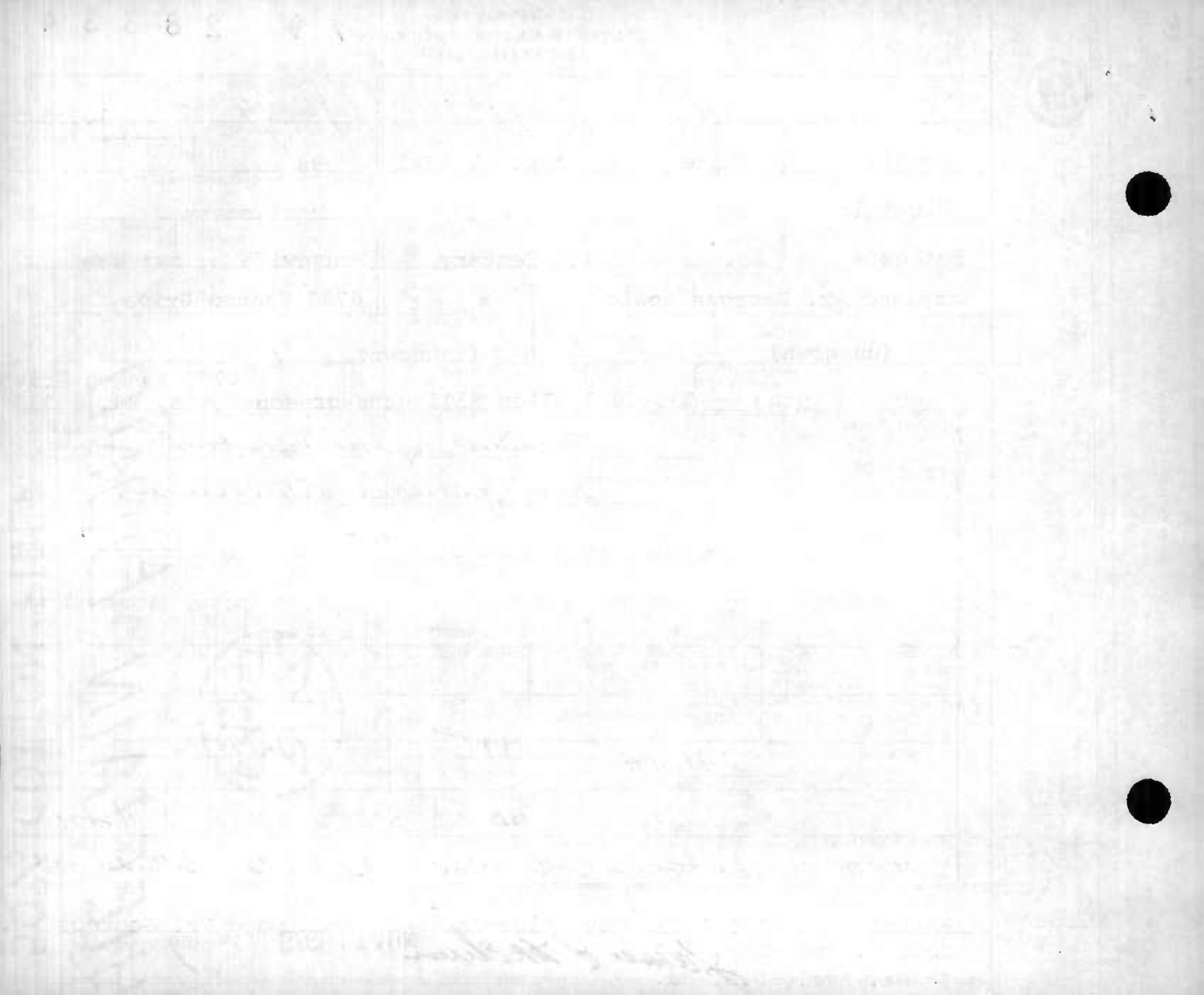
1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE H. Boyd</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/6/79</b>		2b. HOUR A <b>0:15</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 17 1881</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>98</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Health Centery</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Georges</b>		13c. CITY OR TOWN <b>Bowie</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>(unknown)</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(unknown)</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-50-1557</b>		17. INFORMANT <b>Ken Ellington-gr-son-Bowie, Md. 20715</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Stroke generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> , 19 <b>11/6/79</b> , to <b>11/6/79</b> , 19 <b>11/6/79</b> , that (I) (we) last saw the deceased alive on <b>10/24/79</b> , 19 <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/6/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSOOTH LERAGUL</b>		22e. ADDRESS <b>7405 arlington Rd Bethesda Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-9-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Georges Md.</b>		23e. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>				
23f. ADDRESS <b>8434 Ga. Ave., S.E. Md.</b>						

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

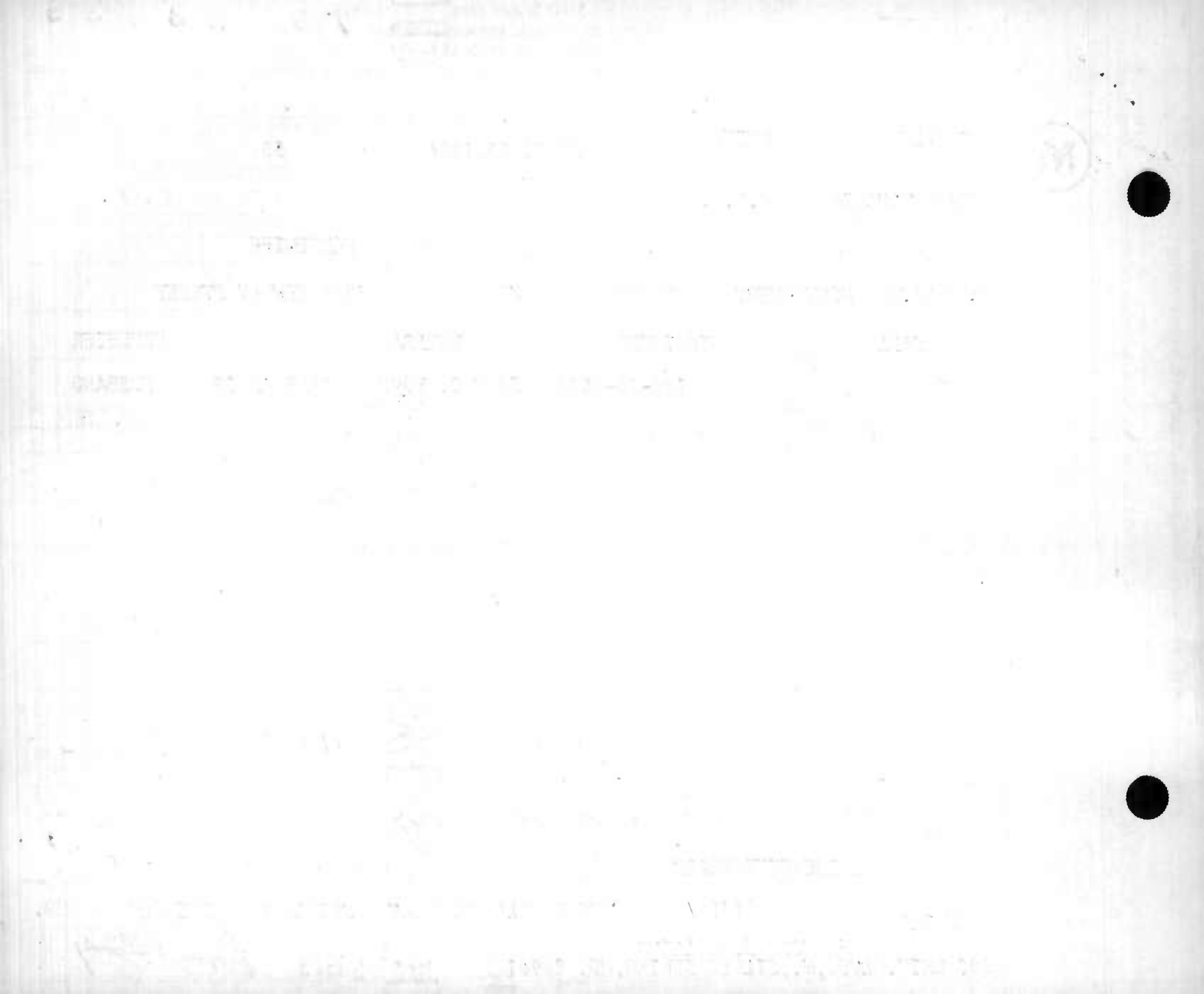


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 3 3 5	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
KATHERINE L. BOYD						11 9 79			8 <sup>30</sup> PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		APRIL 23, 1928		53 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.				MONTGOMERY CO. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN HOSPITAL						HOUSEWIFE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
			MARYLAND			MONTGOMERY			WHEATON		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
CARL WIESINGER			TERESA NEUMEIER						3709 KENWAY STREET		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			188-20-6288			JOHN C. BOYD			SAME AS 13 HUSBAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac tamponade</u> 4410 DUE TO, OR AS A CONSEQUENCE OF (b) <u>dissecting Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> , 19 <u>79</u> , to <u>11-9</u> , 19 <u>79</u> , that (I) (we) lost <u>11-9</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE OF DEGREE <u>J. Blaine Fitzgerald MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/10/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. BLAINE FITZGERALD</u>						22e. ADDRESS <u>8218 Wisconsin Ave. Bethesda</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			11/13/79		CEDAR HILL CEMETERY		SUITLAND PRI GEO MD.				
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						NOV 15 1979					



BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL J. BRACKEN SR.</b>										20. DATE KNOWN OF DEATH ESTIMATED <b>Nov. 25, 1979</b>	
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>23</b> YEAR <b>1914</b>		6. AGE IN YEARS (LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>Nov. 25, 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
13a. STATE <b>W. Va.</b>				13b. COUNTY <b>Marion</b>		13c. CITY OR TOWN <b>Fairmont</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1024 Bryant St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel F. Bracken</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Coughlin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW 11</b>				16b. SOCIAL SECURITY NO. <b>232-05-1614</b>		17. INFORMANT (Funeral Home) <b>R.C. Jones Fairmont, W. Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial</b> <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <b>Chronic Myocardial Dist</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 yrs.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.						TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER			DATE SIGNED <b>Nov. 25, 1979</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>						ADDRESS <b>Silver Spring, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-28-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fairmont Marion W. Va.</b>			
24. FUNERAL DIRECTOR <b>Warner E. RymxPumphrey, Inc.</b> <b>8434 Ga. Ave., S.S. Md.</b>						25a. DATE BY REGISTRATION <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Daniel McCoy Braddock					2a. DATE OF DEATH MONTH DAY YEAR November 24, 1979			2b. HOUR 5:30 PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 5, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3206 Gleneagles Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreign Service of State		12b. KIND OF BUSINESS OR INDUSTRY Dept.		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John S. Braddock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine McCoy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 60 0798		17. INFORMANT ADDRESS Virginia L. Braddock, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> 1552 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Liver</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>79</u> , to <u>Nov. 24</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov. 23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>A. Shamim MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/25/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ahmad Shamim, M.D.					22e. ADDRESS 12205 Barclay Pl. Laurel Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/26/79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia				
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND					25a. DATE REC'D. BY REGISTRAR NOV 29 1979		25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>			

3203



RECEIVED  
FEB 11 1970  
FBI - NEW YORK

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several lines of text that are mostly illegible due to the quality of the scan.]

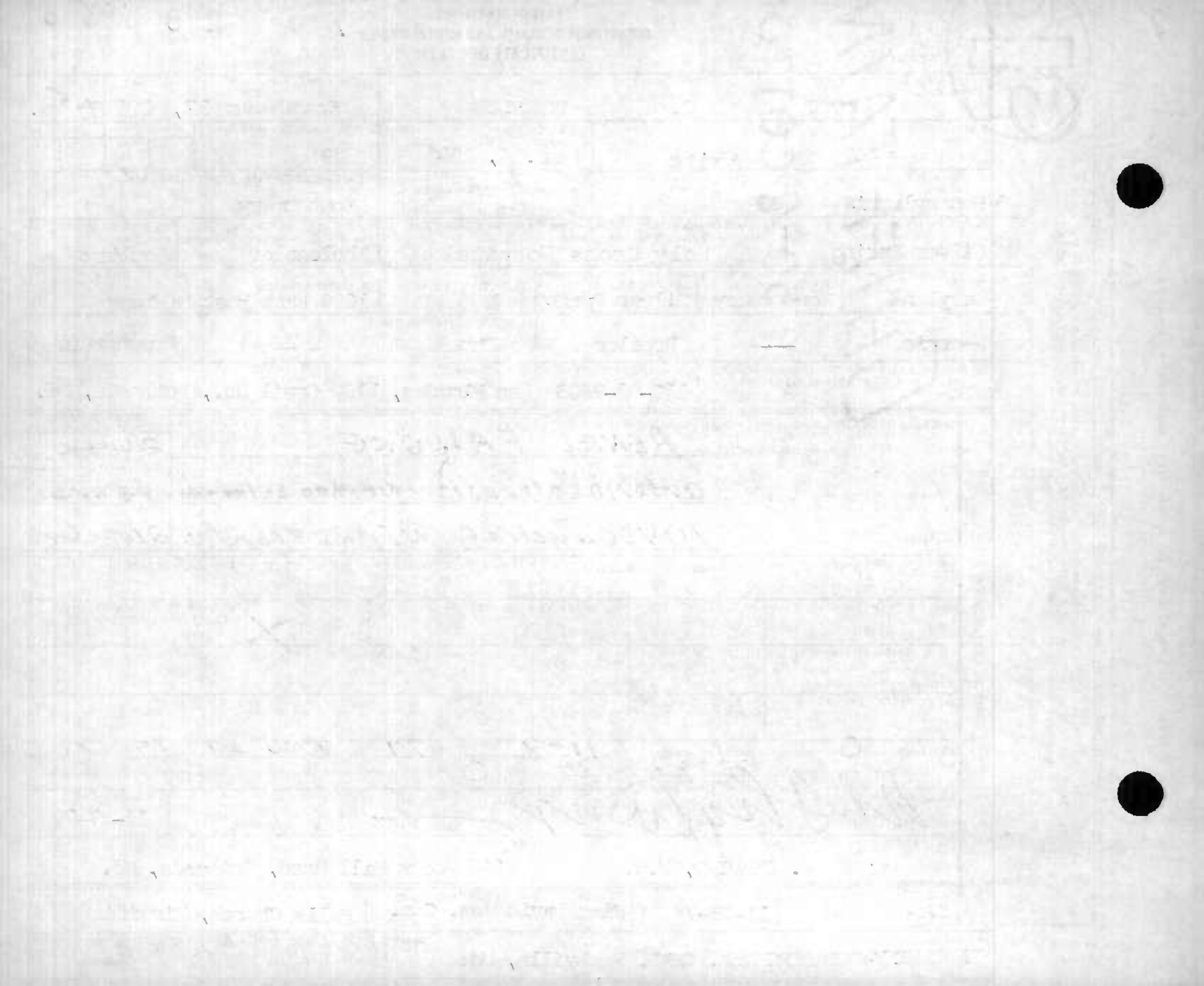
REG. NO



**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

DHMH-16 50M 7/77  
(VR A 15 (4))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

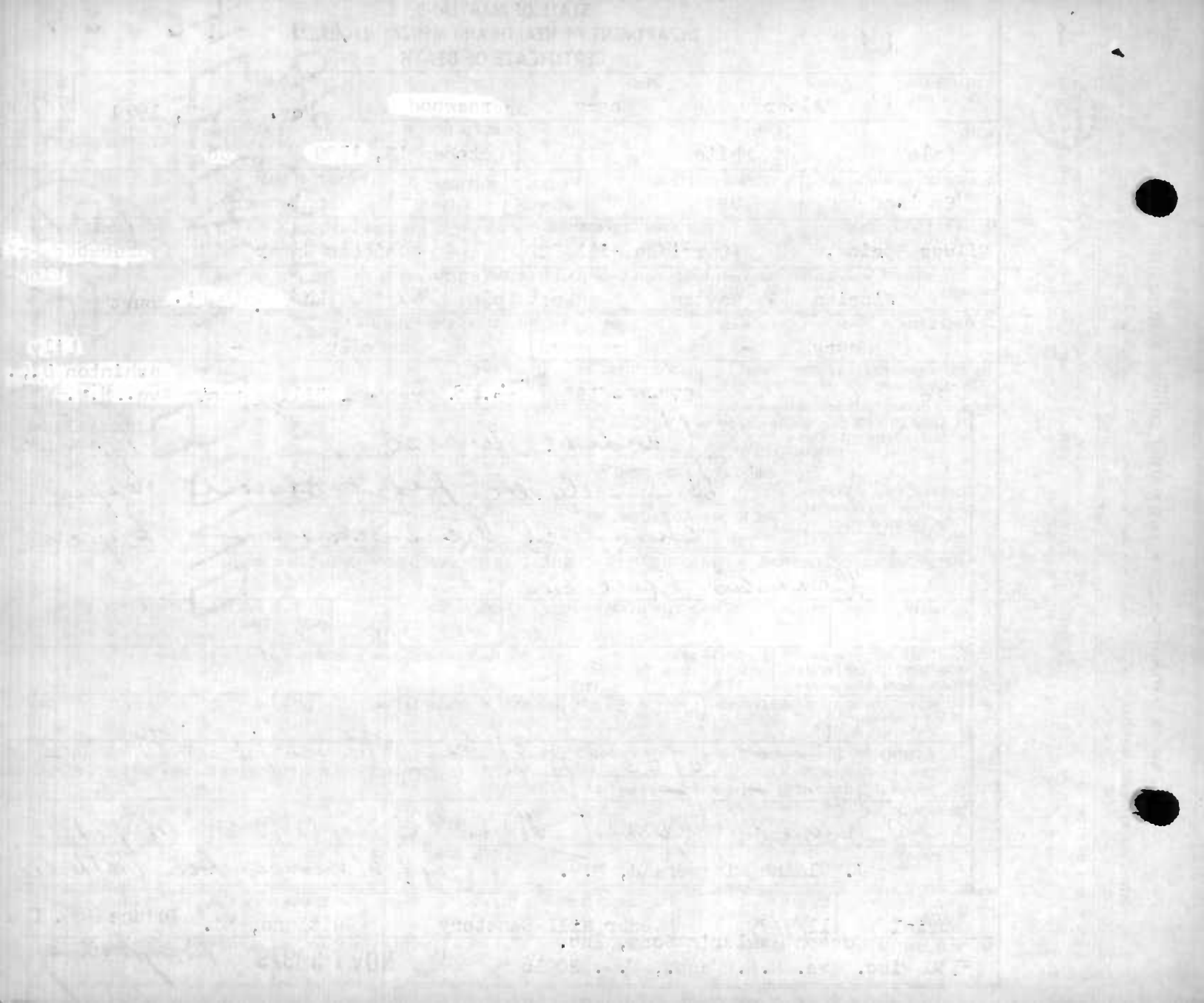
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Office of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 8 3 3 9

1. DECEASED-NAME (Type or print) / <b>Albert Henry Brewood</b>			2a. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>1979</b>			2b. HOUR <b>7:48</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 13, 1887</b>		6. AGE (In years lost birthday) <b>92</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring,</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carriage Hill ECF</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Business Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Florida</b>		13b. COUNTY <b>Dayton</b>		13c. CITY OR TOWN <b>West Palm</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Henry - Brewood</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Emily - Lilly</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			
16a. SOCIAL SECURITY NO. <b>877-03-8180</b>		17. INFORMANT <b>Mrs. Merrill Drennan</b> Address <b>Columbia Md. 20144</b> <b>5681 C Harpers Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>6 years</b> <b>6 years</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/30</b> , 19 <b>73</b> , to <b>11/7</b> , 19 <b>79</b> , that (I) <b>(was)</b> last saw the deceased alive on <b>10/24</b> , 19 <b>79</b> , and that in (my) <b>(own)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(was)</b> (did) <b>(did not)</b> view the body after death.							
22b. SIGNATURE <b>J. Blaine Fitzgerald</b>				22c. DATE SIGNED <b>11/7/79</b>		22d. PHYSICIAN'S NAME (Type) <b>J. Blaine Fitzgerald, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md. Prince Geo. Co.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

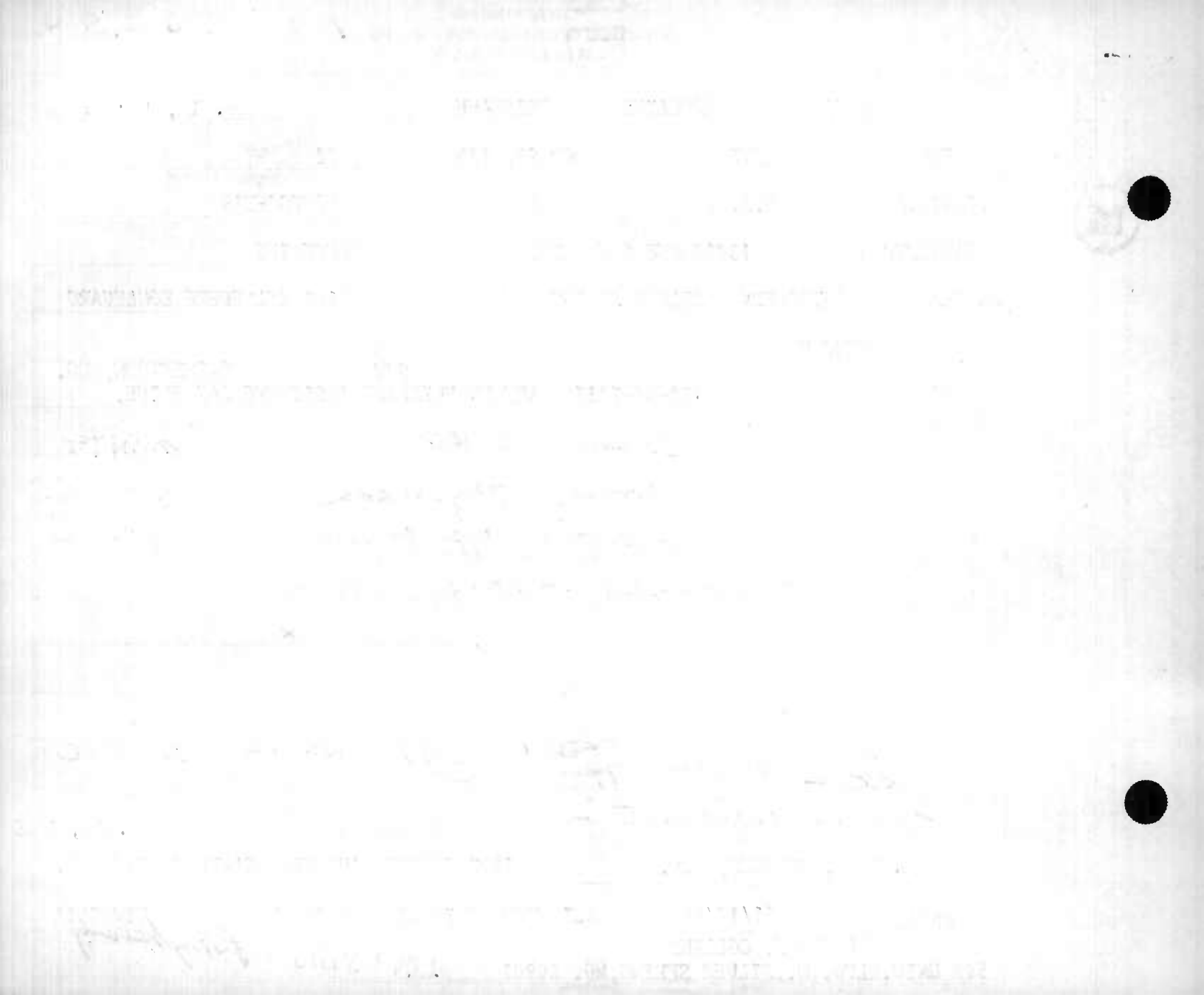
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNA MADELINE BRISBANE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 12, 1979</b>		2b. HOUR <b>8:25A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 23, 1896</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>DARNESTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13213 WYE OAK DRIVE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		
12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-64-7417</b>		17. INFORMANT <b>SON</b> ADDRESS <b>DARNESTOWN, MD.</b> <b>ARTHUR BRISBANE 13213 WYE OAK DRIVE,</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Essential Hypertension</b> Approximate interval between onset and death <b>minutes</b> <b>years</b> <b>years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Esophageal Stricture, Chronic</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (a) (this hospital) attended the deceased from <b>FEB. 1</b> , 19 <b>77</b> , to <b>Nov. 12</b> , 19 <b>79</b> , that (b) (we) last saw the deceased alive on <b>NOV. 12</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we did) (did not) view the body after death.						
22b. SIGNATURE <b>James A. Roberts M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Nov. 12, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. ROBERTS, M.D.</b>		22e. ADDRESS <b>8907 GEORGIA AVENUE, SILVER SPRING, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARLINGTON VIRGINIA</b>						
24. FUNERAL DIRECTOR'S NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>		
25b. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7 9 2 8 3 4 1			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
Miles Terry Bryant				November 1, 1979		11:57 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Negro		December 18, 1954		24 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Indiana		U S A				Montgomery County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Clinical Center, Bethesda, Md NIH		Apprentice plumber-Plumbing			
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS	
Indiana				Allen		3017 S. Monroe St. 46806	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Miles S. Bryant				Minnie Mae Washington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				317-62-5314		Mrs. Minnie Bryant, Mother (same as above)	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: Cardiac Standstill IMMEDIATE CAUSE (a) <u>17/9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension - Acidosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Leiomysarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 Year</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 5, 1979</u> , to <u>November 1, 1979</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>November 1, 1979</u> , and that in <u>xx</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <u>Thistlethwaite</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J.R. Thistlethwaite, Jr.</u>				22e. ADDRESS <u>National Institutes of Health Clinical Center, Bethesda, Md. 20205</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/5/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Covington Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Ft. Wayne, Allen Co. Ind.</u>	
24. FUNERAL DIRECTOR NAME <u>W. W. Chambers Co., Silver Spring, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 06 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Marvin L. Burdette</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 11, 1979</b>			2b. HOUR <b>4:55am</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11, 1915</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>64</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Montgomery</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6520 Damascus Rd.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Edward L. Burdette</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Inez Thomas</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-40-4707</b>		17 INFORMANT ADDRESS <b>Juanita T. Burdette, Item 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis - prob. prostate</b> <b>185-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 6</b> 19 <b>79</b> to <b>Nov. 11</b> 19 <b>79</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>Nov. 10</b> 19 <b>79</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I/we) <del>(did)</del> (did not) view the body after death.									
22b. SIGNATURE <b>Frederick Moomau, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>Nov. 11, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederick Moomau, M.D.</b>					22e. ADDRESS <b>18111 Prince Phillip Dr., Olney, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 14, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Meth.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Browningsville, Montg., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, Damascus, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

9  
9

0100 BP



BP

DHMH - 17  
(VR 115 ME (53))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE INDICATE THE REASON THEREON. THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE INDICATE THE REASON THEREON. THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE INDICATE THE REASON THEREON.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		20. DATE KNOWN OF DEATH ESTIMATED MATED Nov 19 1979										2b. HOUR 23	
1. DECEASED NAME (TYPE OR PRINT)		21. DATE OF DEATH MATED Nov 19 1979										2b. HOUR 23	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Jan 25 01 22 YRS.		6. AGE IN YEARS (LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Nov 19 1979	2d. HOUR 23
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Railroader		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Pa.		13b. COUNTY Beaver		13c. CITY OR TOWN South Heights		13d. INSIDE CITY LIMITS? YES NO		13e. STREET ADDRESS 66 Oak St.					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph W. Burkey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 715-12-0270		17. INFORMANT Joseph Burkey, III		ADDRESS 66 Oak St. (15001) South Heights, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES NO							
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH WHILE AT WORK NOT WHILE AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident Suicide Homicide Undetermined manner		Autopsy Inspection Inquiry											
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED Nov 19 1979							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS 1919 Seminary Rd., Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 23, '79		23c. NAME OF CEMETERY OR CREMATORY Sylvania Hills Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Rochester Beaver Pa.							
24. FUNERAL DIRECTOR NAME James J. Darroch Funeral Home		ADDRESS 2640 Mill Street, Aliquippa, Pa.		25a. DATE RECEIVED BY REGISTRAR Nov 23 1979		25b. REGISTRATION NO. 100734							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

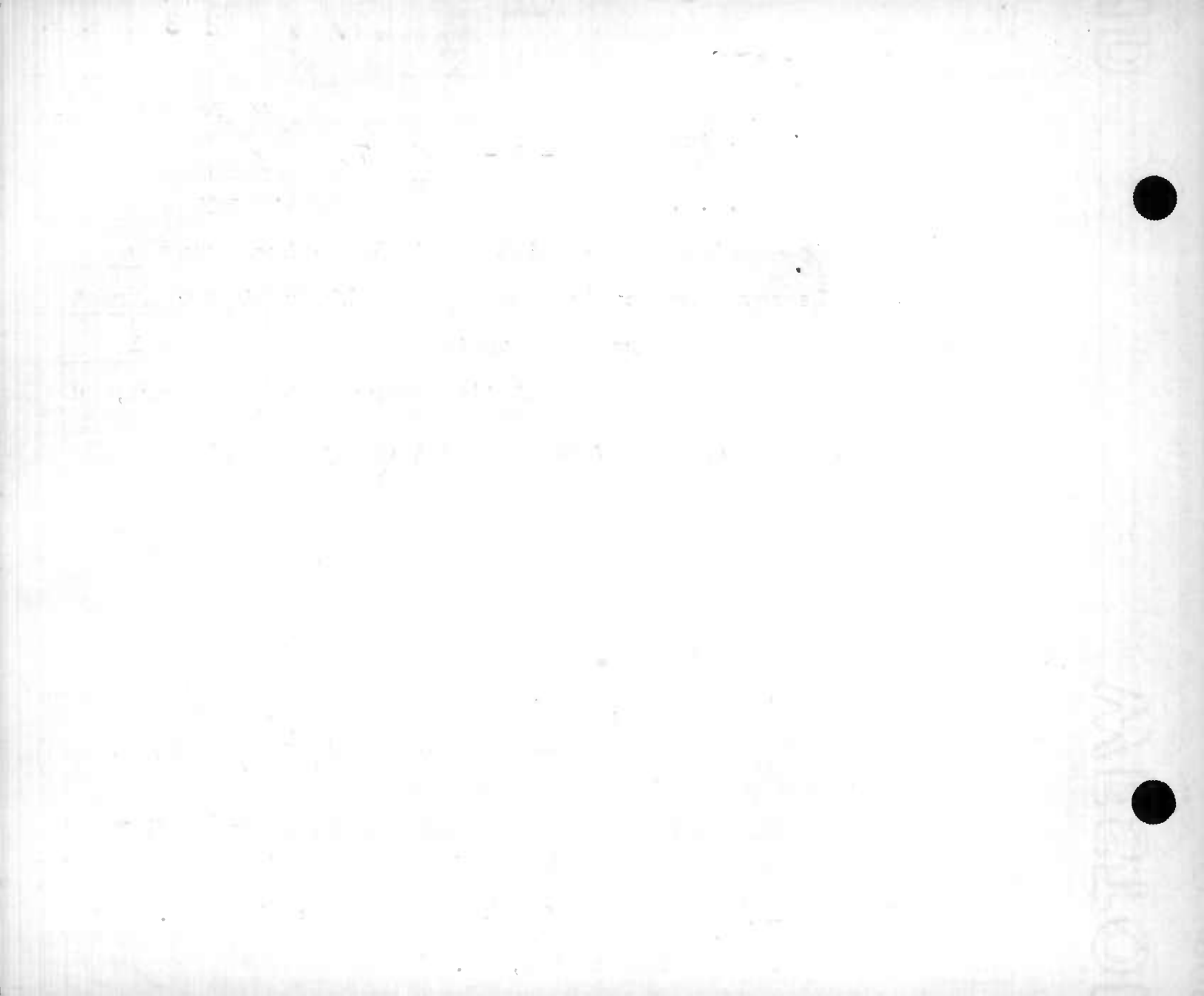
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 3 4 4			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eliza Mildred Byers</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>11 30 79</i>				2b. HOUR <i>8 15</i> A.M.			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 - 3 - 1905</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.							
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Nurse</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> 13b. COUNTY <i>Allegany</i> 13c. CITY OR TOWN <i>Lonaconing</i>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>12 Washington Street</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Adam Byers</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Ball</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>William Byers College Park, Md</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic adenocarcinoma from primary in head of pancreas</i> 1570 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 mos.</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION <i>4/79</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>11/1/79</i> , 19 <i>79</i> , to <i>11/30/79</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/29</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <i>Carol Pressey</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>11/30/79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CAROL PRESSEY</i>				22e. ADDRESS <i>7718 MAPLE AVE, #4, TAKOMA PARK, MD. 20012</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/3/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Lonaconing A. Md</i>					
24. FUNERAL DIRECTOR NAME <i>Eichhorn Funeral Home</i>						24b. ADDRESS <i>Lonaconing, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 6 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>			

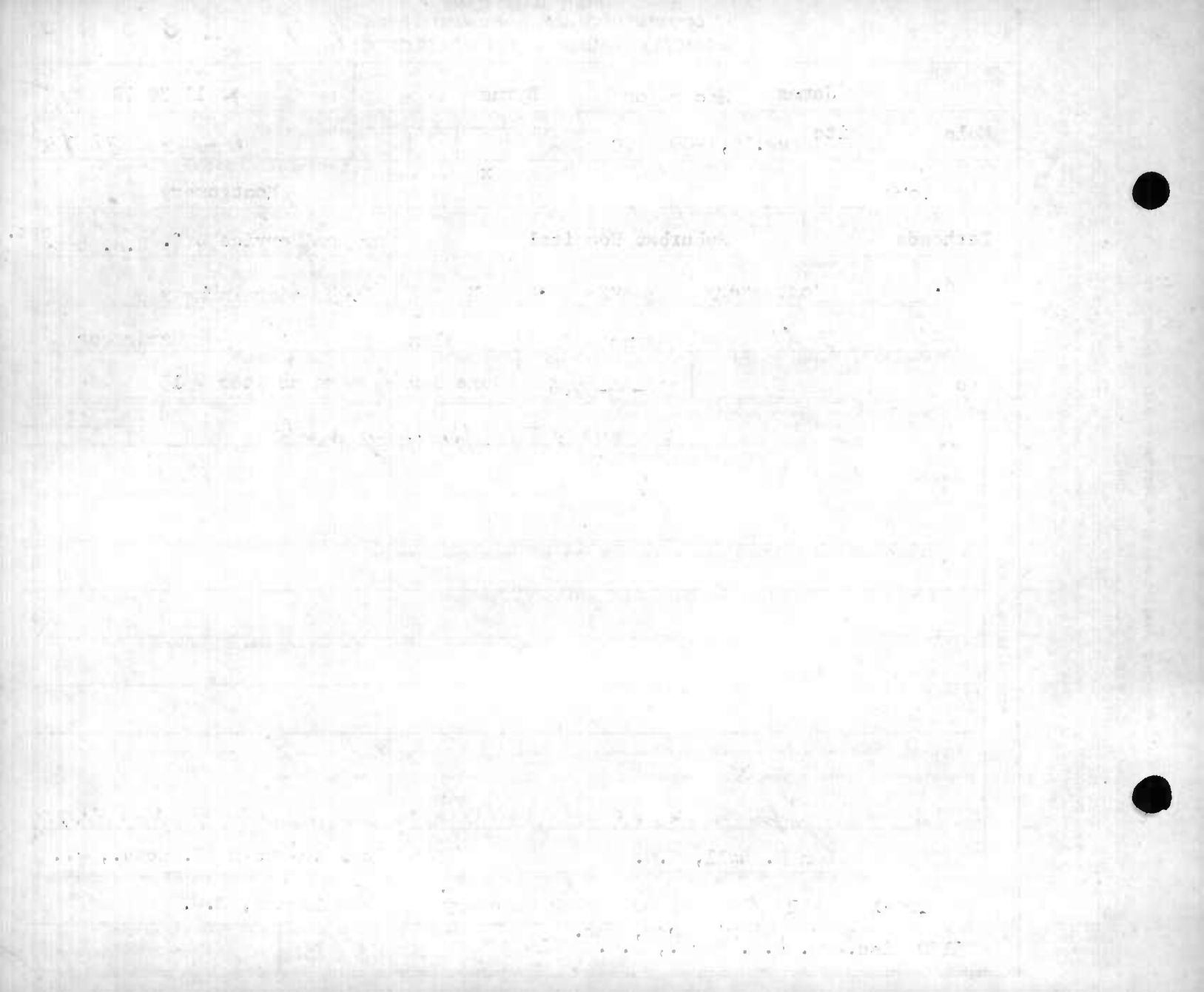
BP \_\_\_\_\_





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										9 28345	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James MacGregor Byrne</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11 30 79</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 18, 1909</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>70</b> YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2b. HOUR OF ESTI. MATED <b>7:15</b> M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov-30 1979</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreign Service Off.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. State Dept.</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.											
13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Chevy Chase</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>5904 Cedar Parkway</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>James Byrne</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen MacGregor</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-44-3706</b>			17. INFORMANT <b>June Byrne</b>			ADDRESS <b>Same as Item # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>411- IMMEDIATE CAUSE (a) Coronary Insufficiency Acute</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>DATE SIGNED Nov 30, 1979</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>7936 Old Georgetown Rd. Beth., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>James MacGregor</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Albert M. Byrnes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 6, 1979</b>		2b. HOUR <b>9:45</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 18, 1909</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS MONTHS DAYS		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery,</b> MD.		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Not available</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mae not available</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577 30 2395</b>		17. INFORMANT ADDRESS <b>Lola H. Byrnes same as item 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Melanoma</b> <b>1729</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>approx 3 yrs</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION <b>2/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> 19 <b>79</b> to <b>present</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>yesterday</b> <b>11/5</b> <b>1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Max Cohen M.D.</b>		22c. DATE SIGNED <b>11/6/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Max Cohen, M.D.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial</b>		
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1979</b>		

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond A. Callahan			2a. DATE OF DEATH MONTH DAY YEAR November 28, 1979			2b. HOUR 9:55P M			
3 SEX Male		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR July 26 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Sealtest Dairy			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Callahan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Lanahan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT ADDRESS Helen O. Callahan (Same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>2500</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAY</u> <u>2 YRS</u> <u>10 YRS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CARDIO-RESPIRATORY DISEASE</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> 19 <u>76</u> , to <u>NOV</u> 19 <u>75</u> , that (I) (we) last saw the deceased alive on <u>NOV 24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leo Donovan M.D.</u>					DEGREE M.D.		22c. DATE SIGNED 11/29/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leo Donovan M.D.					22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-1-79		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Md.		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 8 3 4 8  
**CERTIFICATE OF DEATH**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>JOSEPHINE P. CALVAGNA</b>			2a. DATE OF DEATH 11 Month 9 Day 79 Year		2b. HOUR 7:00 M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>JAN 1, 1909</b>		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>MONTGOMERY</b>		
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>10000 BRUNSWICK AVENUE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>ADM. ASSISTANT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>RALPH W. PAYNE CO</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>10000 BRUNSWICK AVENUE</b>	
14. FATHER'S NAME First Middle Last <b>MICHAEL PYNE</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>AGNES PETERSEN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>579-03-0769</b>	17. INFORMANT <b>DAUGHTER RITA M. VENEZIANI</b>		Address <b>14010 S.E. 46TH ST BELLEVUE WASH</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>496 - ACUTE CARDIAC ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE YEARS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>COR PULMONALE + ARTERIOCLERITIC HEART DISEASE</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>April, 1977</b> to <b>11-9, 1979</b> , that (I) (we) saw the deceased alive on <b>10-6-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jason Geiger M.D.</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>JASON GEIGER M.D.</b>		22e. ADDRESS <b>5830 CAMERON STREET SILVER SPRING, MD. 20910</b>		22c. DATE SIGNED <b>11-9-79</b>	
23a. BURIAL, CREMATION, REINTERMENT <b>BURIAL</b>	23b. DATE <b>11/13/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b>		ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. REC'D BY REGISTRAR <b>NOV 15 1979</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 4 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

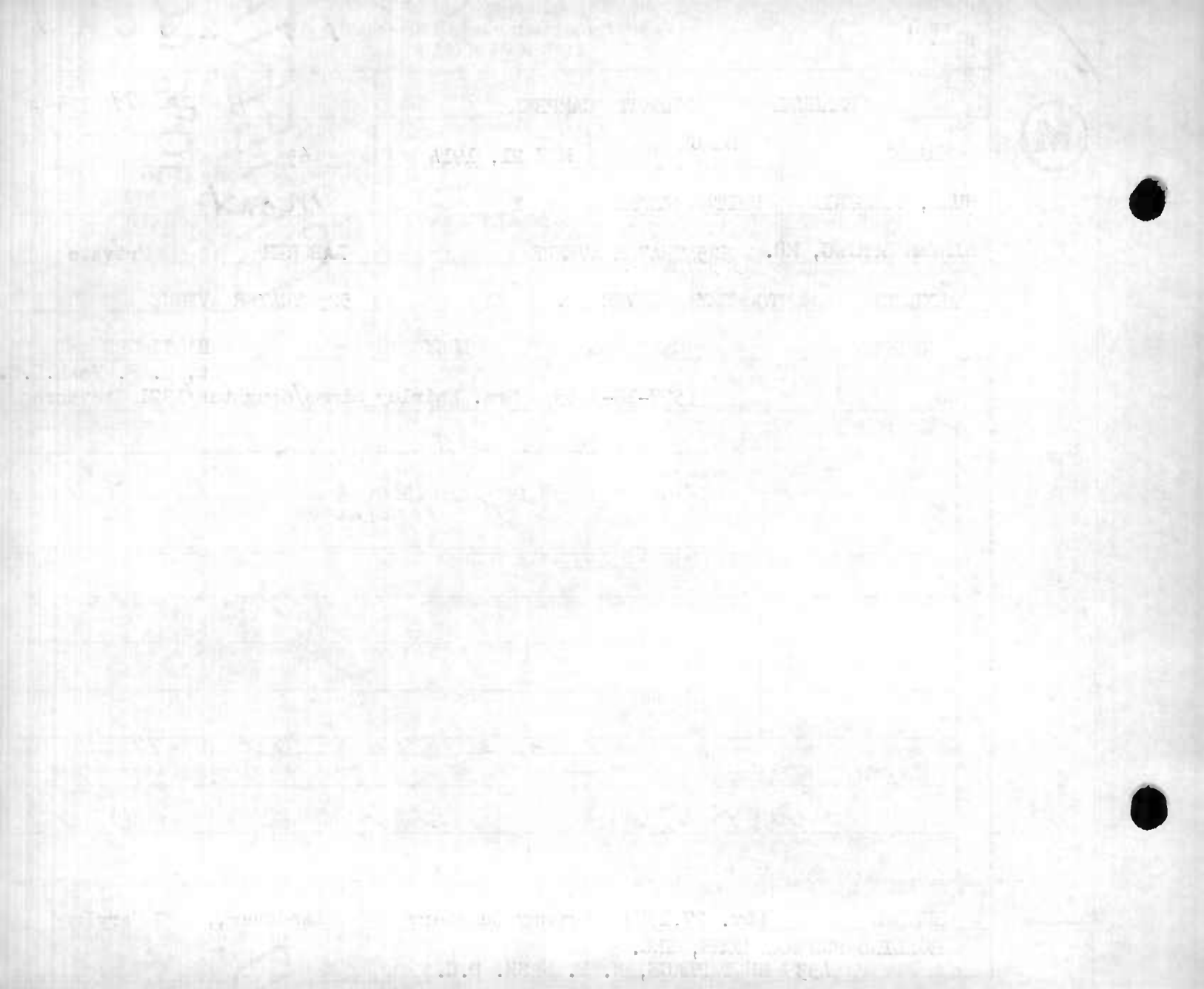
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMANUEL HERBERT CAMPBELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 22 79</b>		2b. HOUR <b>3:30p</b>
3 SEX <b>MALE</b>	4 RACE <b>BLACK</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>MAY 21, 1914</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>HUME, VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Mont.</b> MD.		
10 CITY OR TOWN OF DEATH <b>SILVER SPRING, MD.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>525 THAYER AVENUE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SP.</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>525 THAYER AVENUE</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>HERBERT CAMPBELL</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY BALTIMORE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>577-18-3055</b>		17. INFORMANT ADDRESS <b>Mrs. Shirley Simms/daughter/1321 Stevenson St., S. E. Wash.D.C.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>carcinoma of lung, with bone metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastases</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 Mo</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/13</b> 19 <b>79</b> to <b>9/14</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/17/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Deborah B Goldberg</b>		DEGREE		22c. DATE SIGNED <b>11/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Deborah B Goldberg</b>		22e. ADDRESS <b>1106 Spring St, Silver Spring</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>Nov. 27, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, PG Maryland</b>		24. FUNERAL DIRECTOR <b>ROLLINS FUNERAL HOME, INC.</b> <b>4339 HUNT PLACE, N. E. WASH. D.C.</b>			
25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 3 5 0							
1- FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
JOHN THOMAS CAMPBELL						NOVEMBER 06, 1979				1650						M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
MALE		CAUCASIAN		SEPT. 30, 1920		59		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
VIRGINIA		USA				BETHESDA, MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA				NATIONAL NAVAL MEDICAL CEN.				USN/RET									
13a. STATE						13b. CITY OR TOWN		13c. STREET ADDRESS									
VIRGINIA						FAIRFAX		FALLS CH.		1939 STORM DR.							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
CECIL THOMAS CAMPBELL				GRACE RILEY													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS							
YES				WW II Korean		SON				628 N. HAMILTON ST. N.C. 27260							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEIOMYOSARCOMA, CARDIO-RESP. ARREST</u> <u>1719</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1325 31 OCT 19 79</u> to <u>1650 06 NOV 19 79</u> , that (I) (we) lost saw the deceased alive on <u>06 NOV 79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.																	
22b. SIGNATURE <u>George T. Gamblin</u>										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 06 NOV 79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE T. GAMBLIN MD.										22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL				11/9/79		ARLINGTON NAT'L				ARLINGTON VA							
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MURPHY FALLS CHURCH FUNERAL HOME FALLS CHURCH										NOV 09 1979		<u>Henry McCreedy</u>					

MEDICAL CERTIFICATION

29

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>James J. Carley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 19 79</b>			2b. HOUR <b>10:15 PM</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>APRIL 12, 1890</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IRELAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RESTAURANT OWNER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>3662 EDELMAR TERRACE</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN CARLEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT NAME ADDRESS <b>DAUGHTER 7891 PATRIOT DRIVE MARY D. WOODS ANNANDALE, VIRGINIA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 3319 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe diffuse cortical (cerebral) atrophy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiac - embolism</b> diffusely PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Parkinsonism</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b>									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Fall of 1976</b> to <b>19 Nov 1979</b> , that (I) (we) last saw the deceased alive on <b>19 Nov 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gustavo S. Belaval, MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>19 Nov 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GUSTAVO S. BELAVAL</b>						22e. ADDRESS <b>Leisure World Medical Center Silver Spring, Md 20832</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>		
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL L. CARNEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11/10/79</b>					2b. HOUR <b>12:45</b>
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6/14/98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT. Kensington MD.</b>				
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D. C. Public Schools</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Washington, D. C.</b>					13b. CITY OR TOWN <b>Wash., D. C.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1666 Primrose Road, N. W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Matthew J. Carney</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Lamb</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-60-2460</b>		17. INFORMANT <b>Mrs. Nelson Mitchell</b>			ADDRESS <b>5411 Western Lane Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Hunt</b> <b>1991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Metastatic Carcinoma</b> (c) <b>Months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>October 24</b> , 19 <b>79</b> , to <b>November 10</b> , 19 <b>79</b> , that (1) (b) last saw the deceased alive on <b>October 8</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (b) saw the body after death.										
22b. SIGNATURE <b>Benjamin Krawin, MD</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>11/10/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Benjamin Krawin, MD</b>					22e. ADDRESS <b>3720 Fountaingate Ave. Ken. Md. 20795</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Nov. 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Prince Geo., Maryland</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisconsin Avenue, N. W.</b> <b>Washington, D. C. 20016</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barry M. [Signature]</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Jessie Caves</i>					2a. DATE OF DEATH MONTH DAY YEAR Nov. 15, 1979			2b. HOUR P. M. 7:56 P.	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 15 83		6. AGE (IN YEARS LAST BIRTHDAY) 96		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel-Pre Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2127 Jennings Road,		
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius D. Kelly					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Cranmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----		16b. SOCIAL SECURITY NO. 527-01-4529A		17. INFORMATION (Daughter-in-law) Mrs. Charles Purves Kensington, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>stroke</i> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic heart disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 19 73 to 11/15, 19 79, that (I) (we) saw the deceased alive on 11-15-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Morris Perry</i>					22c. DATE SIGNED 11-15-79			22d. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Morris Perry, MD					22f. ADDRESS 11602 Georgia Ave., Silver Spring, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-17-79		23c. NAME OF CEMETERY OR CREMATORY West Creek		23d. LOCATION CITY OR TOWN COUNTY STATE West Creek N.J.			
24. FUNERAL DIRECTOR Walter E. Pumphrey, Inc. 8434 Ga. Ave., S.S. MD.					25a. DATE REC'D. BY REGISTRAR NOV 19 1979				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Angela Marie Chase</b> (Baby Girl)		2a. DATE OF DEATH MONTH DAY YEAR <b>11 23 79</b>		7b. HOUR <b>9:45 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 23 79</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>1 YRS 1 DAY 36 HRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>Montgomery</b>		
13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>40200 Independence Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Francis Chase</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Ann Settle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>John F. Chase 40200 Independence St. Rockville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Respiratory Distraction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Suicide</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7651</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>-</b>					
19a. DATE OF OPERATION <b>n.h.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>n.h.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY (HOUR) A.M. MONTH DAY YEAR <b>8:45 PM 11/23 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Brick to Park</b>	
22a. I certify that (1) this hospital attended the deceased from <b>11/23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) (did not) view the body after death.					
22b. SIGNATURE <b>Eugene Sussman, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE SUSSMAN, MD</b>		22e. ADDRESS <b>2401 BLUEWATER SS, MD 20902</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery MD.</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>			
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home</b>		25. REGISTRAR'S SIGNATURE <b>John F. Chase</b>			

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EUGENE SUSSMAN, MD

1331 Rockville  
Rockville, MD

1331 Rockville  
Rockville, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 3 5 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		20. DATE OF DEATH		MONTH DAY YEAR		26. HOUR			
Bessie Wilson Nowlin Cisna		Bessie Wilson Nowlin Cisna		11 13 1979		4:42 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Female		White		June 22 1887		92		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS			
Virginia		USA				Montgomery		HOURS MIN			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Rockville		Potomac Valley Nursing Home		Homemaker		Own Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS							
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS							
Md.		Montgomery		Rockville		Potomac Valley Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
John Henry Nowlin		Sallie Louisa Woodson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		Unknown		W.D. Diuguid, Inc. F.H.		Lynchburg, Va.		1016 Rivermont Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4409		Cardio Respiratory arrest		Generalized Atherosclerosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from July 23 19 78 to Nov 13 19 79, that (I) (we) last saw the deceased alive on 10/18 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
		MIGUEL R CASCARDO		M.D.		11/13/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE					
MIGUEL R CASCARDO		12500 BOBINK CT POTOMAC MARYLAND 20854		NOV 16 1979							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Nov. 15, 1979		Spring Hill Cemetery		Lynchburg Va.					
24. FUNERAL DIRECTOR		ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Joseph Gawler's Sons Inc.		5130 Wisconsin Washington, D.C. 20016		NOV 16 1979							



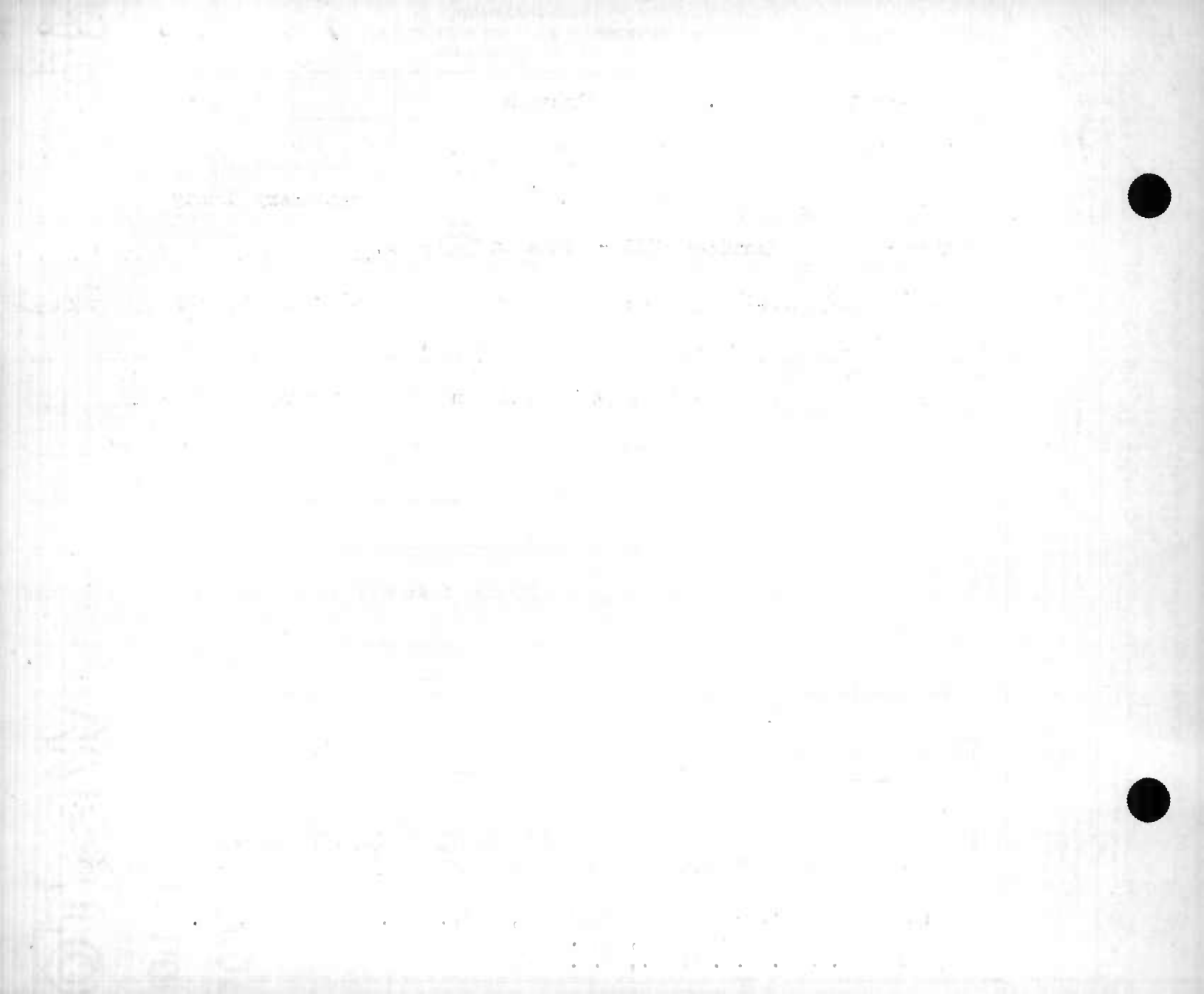


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 5 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Samuel F. Clabaugh</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 30, 1979</b>		2b. HOUR <b>12 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 / 06 / 90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill - Bethesda Cedar La.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OFFICER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b> 13b. COUNTY <b>NONE</b> 13c. CITY OR TOWN <b>Wash, D.C.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4000 Cathedral Ave NW</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Clabaugh</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Graves</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW I WW II</b>				16b. SOCIAL SECURITY NO <b>418-05-1361</b>		17. INFORMANT ADDRESS <b>Maitland Clabaugh Same As Item # 13</b>	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4539</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY EMBOLI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PHLEBOTHROMBOSIS</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b>	
						-	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHRONIC PROGRESSIVE PARKINSON'S DISEASE ; URINARY TRACT INFECTION</b>							
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>- P.M. - 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>-</b>			
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>22 JUNE</b> 19 <b>79</b> , to <b>NOVEMBER</b> 19 <b>79</b> , that (I) <del>(we)</del> <b>lost</b> saw the deceased alive on <b>30 NOVEMBER</b> 19 <b>79</b> , and that in <del>(my)</del> <b>my</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>did not</b> view the body after death.							
22b. SIGNATURE <b>Richard A. Nicklas</b> MD				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD A. NICKLAS MD</b>				22e. ADDRESS <b>(DR. EDWARD NICKLAS' OFFICE) 4830 V ST. NW, WASHINGTON DC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McBrady</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SADIE NMI CLARK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-1-79</b>			2b. HOUR <b>3:55 P M</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5-20-1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b>	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY <b>N.Y.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ALTHEA WOODLAND N.H.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>		13b COUNTY <b>MONT.</b>		13c CITY OR TOWN <b>SILVER SPRING</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Michael Neary</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Quick</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b SOCIAL SECURITY NO. <b>577-76-6435</b>		17 INFORMANT ADDRESS <b>WM. CLARK (SON)</b>					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac standstill</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary atherosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>years</b> <b>years</b>
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
**General atherosclerosis CHF. cerebral decompensation**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9</b> 19 <b>76</b> to <b>11/1</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/1/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>James A. Roberts M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. ROBERTS M.D.</b>				22e. ADDRESS <b>8907 GEORGIA AVE. SILVER SPRING, MD.</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Albany Rural Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Albany, New York</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 05 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



Michael Henry Joseph

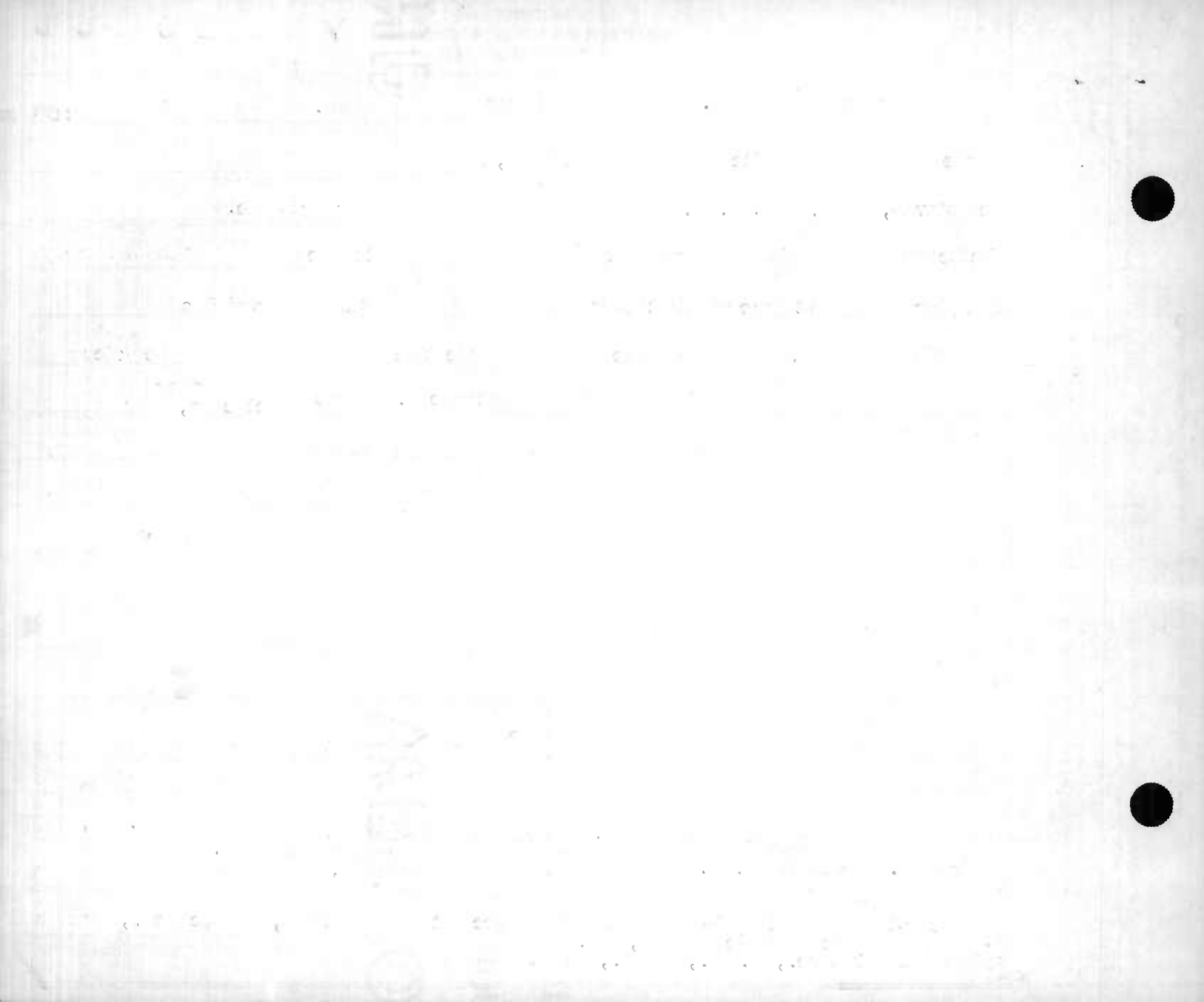
1371 Rockville Lane  
Rockville, Maryland  
Don Wheeler, General Agent  
11545  
Henry Mann Cemetery, Albany, New York

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										7 9 2 8 3 5 8	
1. DECEASED NAME (TYPE OR PRINT) Charles L. Clarke					2a. DATE OF DEATH Nov. 28 1979		2b. HOUR 8:00				
3. SEX male		4. RACE white		5. DATE OF BIRTH July 10, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Haven, Conn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5218 Goddard Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher		12b. KIND OF BUSINESS OR INDUSTRY School for boys			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5218 Goddard Road			
14. FATHER'S NAME Charles C. Clarke					15. MOTHER'S MAIDEN NAME Valentine Lemaieur						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Constance D. Clarke -		ADDRESS 5218 Goddard Road Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>INOPERABLE LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastasis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 16 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 54</u> to <u>Nov 28 1979</u> , that (I) (we) lost saw the deceased alive on <u>Nov 26 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Leo I. Donovan M.D.</u>		DEGREE		22c. DATE SIGNED Nov. 28, 1979							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-28-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Geo., Maryland					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., N. W., Wash., D. C. 20016				25a. DATE REC'D. BY REGISTRAR DEC 3 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 5 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence J. Clements				2a. DATE OF DEATH MONTH DAY YEAR Nov. 19 '79 11:45 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 27 1888		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17501 Old Baltimore Road,		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Catholic	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Clements		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula McGraw		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) none			
16b. SOCIAL SECURITY NO. 577-18-8129A		17. INFORMATION (Daughter) 2116 Drury Road, Faith Smith-Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Multiple Deformities</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>March</u> 19 <u>78</u> , to <u>19 Nov</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>15 Nov</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Lewis Kellert, MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, MD		22e. ADDRESS 1811 Prince Phillip Dr., Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-24-79		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery Forest Glen Montg.		23d. LOCATION CITY OR TOWN COUNTY STATE Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR NOV 23 1979					
25b. REGISTRAR'S SIGNATURE <u>Anthony McBrady</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

Chas. E. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				7 9 2 8 3 6 0 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Ida Virginia Clemons</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 13 79</b>				2b. HOUR <b>10<sup>PM</sup></b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 15, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS YEARS <b>57</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>60</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>210 Congressional Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Adolph</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl V. Divine</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>--</b>		17. INFORMANT ADDRESS <b>Rockville, Maryland</b> <b>Linda Chuthaset 218 Congressional Lane Tl</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cirrhosis of the Liver</b> <b>5715</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia Renal failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9 / 1 19 79</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>9 / 1 19 79</b> to <b>11 / 13 19 79</b> , that (I) (was) last saw the deceased alive on <b>11 / 13 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Antonio G. Uy</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO G. UY MD</b>				22e. ADDRESS <b>831 Univ. Blvd E Silver Spring, Md 20903</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Andrew Chapel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Vienna, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Md. 20852</b>				25. DATE REC'D BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 6 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Gladys E. Clubb</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>11</b> YEAR <b>1979</b>			2b. HOUR <b>3:50<sup>PM</sup></b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>14</b> YEAR <b>1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Holy Cross Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Lady Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hecht Co.</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1401 Blair Mill Road,</b>		
14 FATHER'S NAME FIRST <b>(unknown)</b> MIDDLE <b></b> LAST <b>Polen</b>			15 MOTHER'S MAIDEN NAME FIRST <b>(unknown)</b> MIDDLE <b></b> LAST <b></b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>578-10-8794</b>	
17 INFORMANT (friend) ADDRESS <b>Mrs. James W. Lisanby-Arl. Va. 22202</b>			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute MYOCARDIAL INFARCTION +</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PUMP FAILURE +</b> <b>HEART BLOCK</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>					

## MEDICAL CERTIFICATION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (this hospital) attended the deceased from <b>11/10/1979</b> to <b>11/11/1979</b> , that (I) (we) last saw the deceased alive on <b>11/11/1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Tony P. Kannarkat MD</b>		22c. DATE SIGNED <b>NOV 16 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TONY P. KANNARKAT</b>		22e. ADDRESS <b>8201 16<sup>th</sup> St Silver Spring, MD 20910</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-14-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION CITY OR TOWN <b>Brentwood Pr.</b> COUNTY <b>Georges</b> STATE <b>Md.</b>	
24 FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b> <b>8434 Ga. Ave., S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

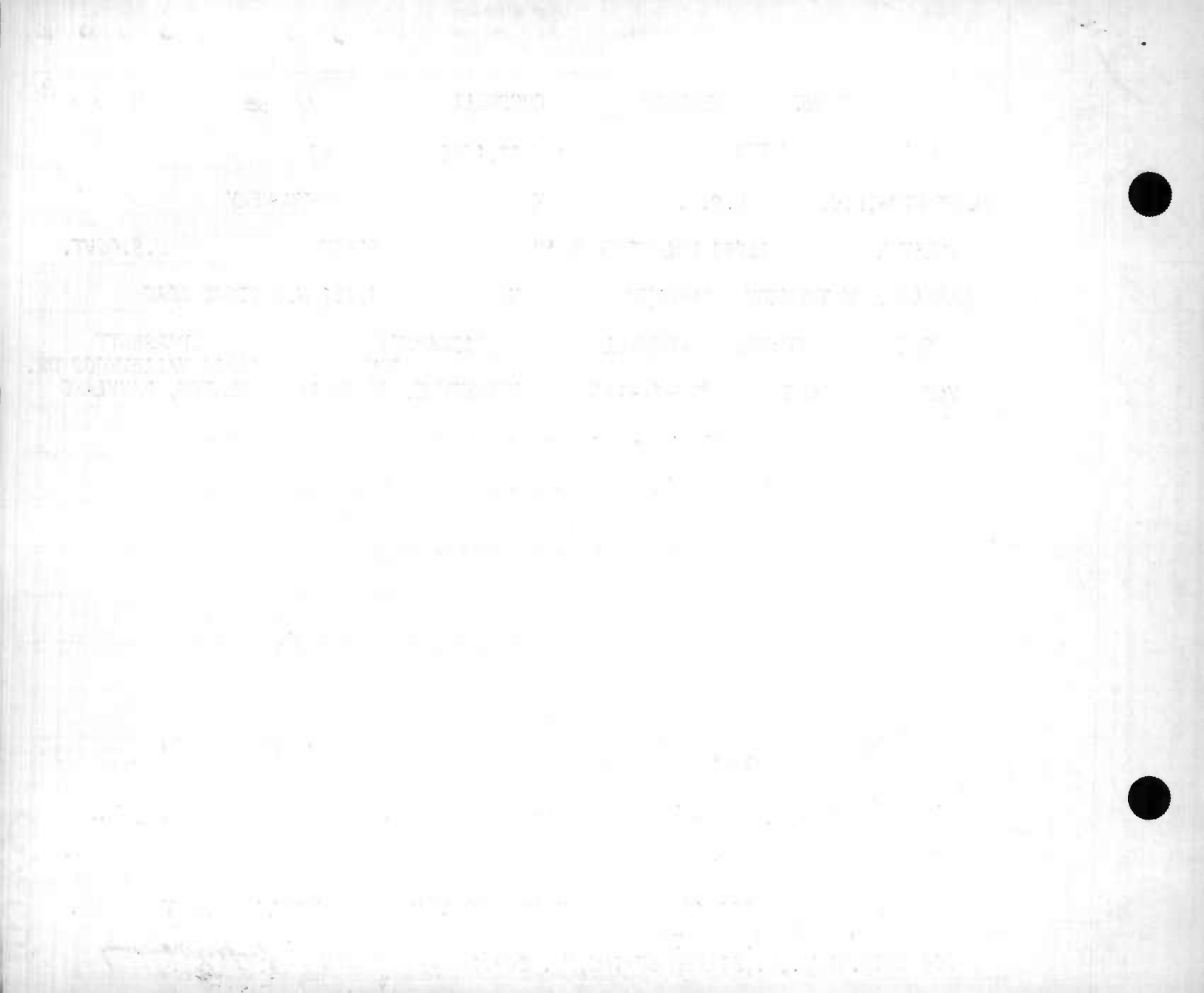
Chick E. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	2	8	3	6	2
1. FOR STATE REGISTRAR		REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		MIN	
FRANK		KENNETH		COGSWELL				11		5	79	6:00		AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
MALE		WHITE		MARCH 13, 1896		83		MONTHS		DAYS		HOURS		MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
WASHINGTON, D.C.		U.S.A.				MONTGOMERY										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
WHEATON		12721 HOLDRIDGE ROAD		CLERK		U.S. GOVT.										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS										
MARYLAND		MONTGOMERY		WHEATON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12721 HOLDRIDGE ROAD								
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME														
FRANK		BOWERS		COGSWELL		ELIZABETH		SPARSHOTT								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS										
YES		WW I		578-10-1434		SON		KENNETH E. COGSWELL		WHEATON, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse - arteriosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart disease - cardiac aneurysms</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
4/40																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>1979</u> to <u>11/5</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Sept.</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Joseph M. Solinas</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/5/79</u>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH M. SOLINAS MD</u>		22e. ADDRESS <u>9501 GEORGIA AVE. S.S. MD 20902</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE										
BURIAL		11/8/79		PARKLAWN CEMETERY		ROCKVILLE MONT MD										
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD, 20901		NOV 8 1979		<u>Francis J. Collins</u>										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF YOU FILE, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

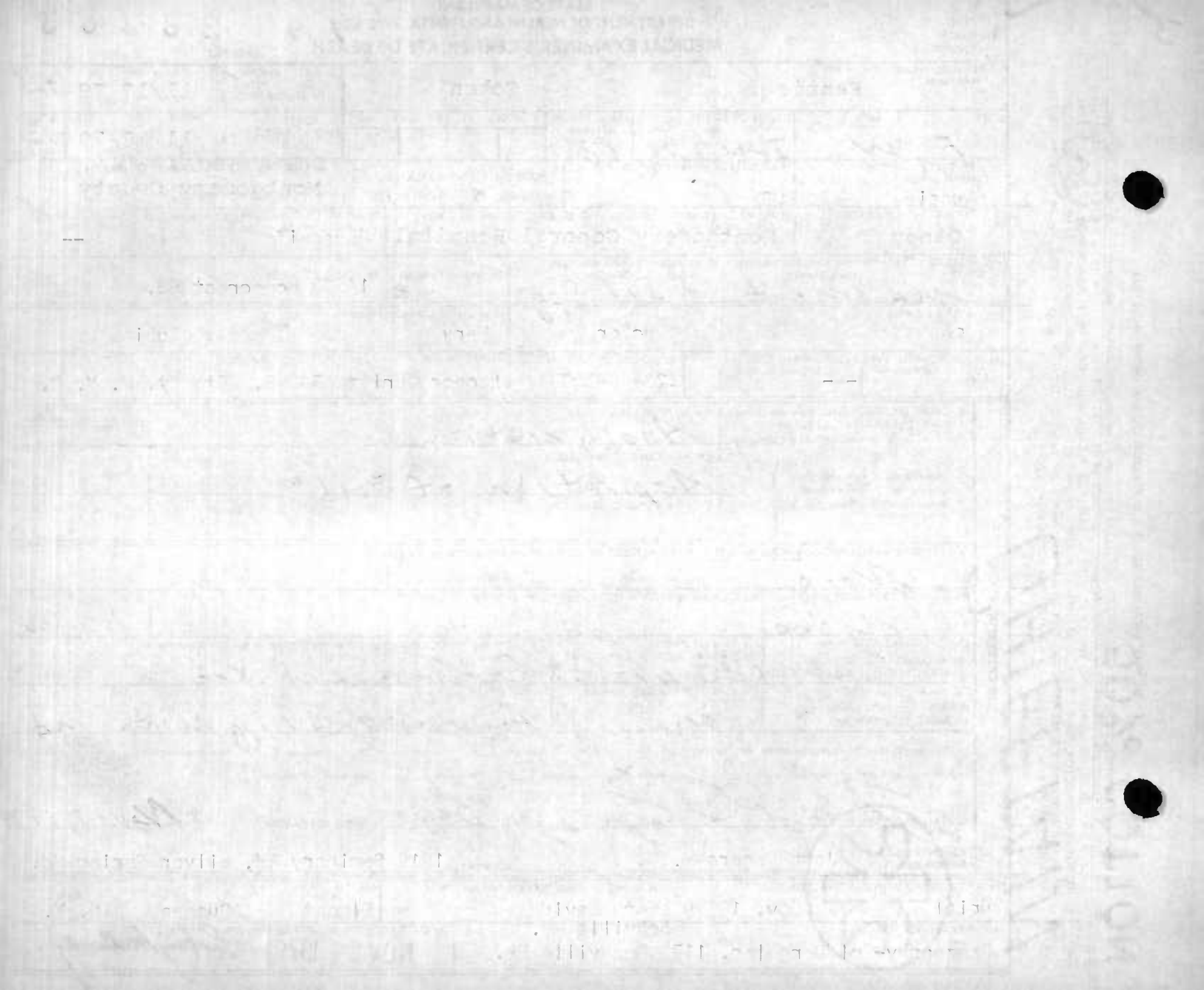
DHM-17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		20. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 11/17/79										21. HOUR 11:30 AM
1. DECEASED NAME (TYPE OR PRINT)		FIRST Fannie		MIDDLE		LAST Cohen						22. HOUR 11:30 AM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR June 7 21 1928		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11/17/79		23. HOUR 11:30 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County						MD.
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN S. L. Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 14508 Homecrest Rd.				
14. FATHER'S NAME FIRST MIDDLE LAST John Duckor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rubin										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 120-26-3937		17. INFORMANT Leonore Kritz		ADDRESS 300 E. 40th St. N. Y. C.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Asphyxiation												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) Aspiration of Food												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
None												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1300 11/17/79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Eating and choked								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET City or Town County State Homecrest Bk S. L. Spg Mont Md								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Def.				MEDICAL EXAMINER				DATE SIGNED Nov 17, 1979		
EXAMINER'S NAME (TYPE OR PRINT) John Rogers M. D.		ADDRESS 1919 Seminary Rd, Silver Spring Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 19'79		23c. NAME OF CEMETERY OR CREMATORY Beth David		23d. LOCATION CITY OR TOWN Elmont		COUNTY Queens		STATE N. Y.		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Inc. ADDRESS 1170 Rockville Pk.				25a. DATE REC'D. BY REGISTRAR NOV 21 1979		25b. REGISTRAR'S SIGNATURE [Signature]						

3203



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

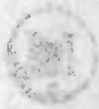
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					7 9 2 8 3 6 4					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MAY MIDDLE E. LAST CONLON					MONTH DAY YEAR HOUR					
3. SEX FEMALE					4. RACE WHITE					
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)					
MONTH DAY YEAR OCT 23, 1884					95 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					
PENNSYLVANIA					U.S.A.					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION					
ROCKVILLE					POTOMAC VALLEY NURSING HOME					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					
HOUSEWIFE										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
MARYLAND			MONTGOMERY			CHEVY CHASE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST JOHN EVANS					FIRST MIDDLE LAST SUSAN EVERELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT
NO										ADDRESS
					JOHN CONLON					SAME AS 13
										SON
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis										
4409 DUE TO, OR AS A CONSEQUENCE OF										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR							
			P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION				
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 7-7, 1975, to 11-12, 1979, that (we) last saw the deceased alive on 11-8, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
James W. Egan M.D.					11/12/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
James W. Egan					5413 Cedar Ln - Bethesda, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL			11/15/79		GATE OF HEAVEN		SILVER SPRING			
							CITY OR TOWN COUNTY STATE			
							MONTGOMERY MD.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				
NAME FRANCIS J. COLLINS						25b. SIGNATURE				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						NOV 15 1979				

5200 BP





NO	JOHN COLVIN	SALE AS IS	201
JOHN	EVANS	SUGAR	EVERETT
MARYLAND	MONTGOMERY	CHERRY CHASE	3212 TURNER LANE
ROCKVILLE	POTOMAC VALLEY	WESTING HOUSE	INDUSTRIE
PENNSYLVANIA	U.S.A.	XX	MONTGOMERY
FEMALE	WHITE	OCT 21 XXXX 1922	92

500 W. 11th St., W. 11th St., W. 11th St.  
FRANCIS J. COLLINS  
11/12/79  
GATE OF HEAVEN  
SILVER SPRING  
MAY 1 1980



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

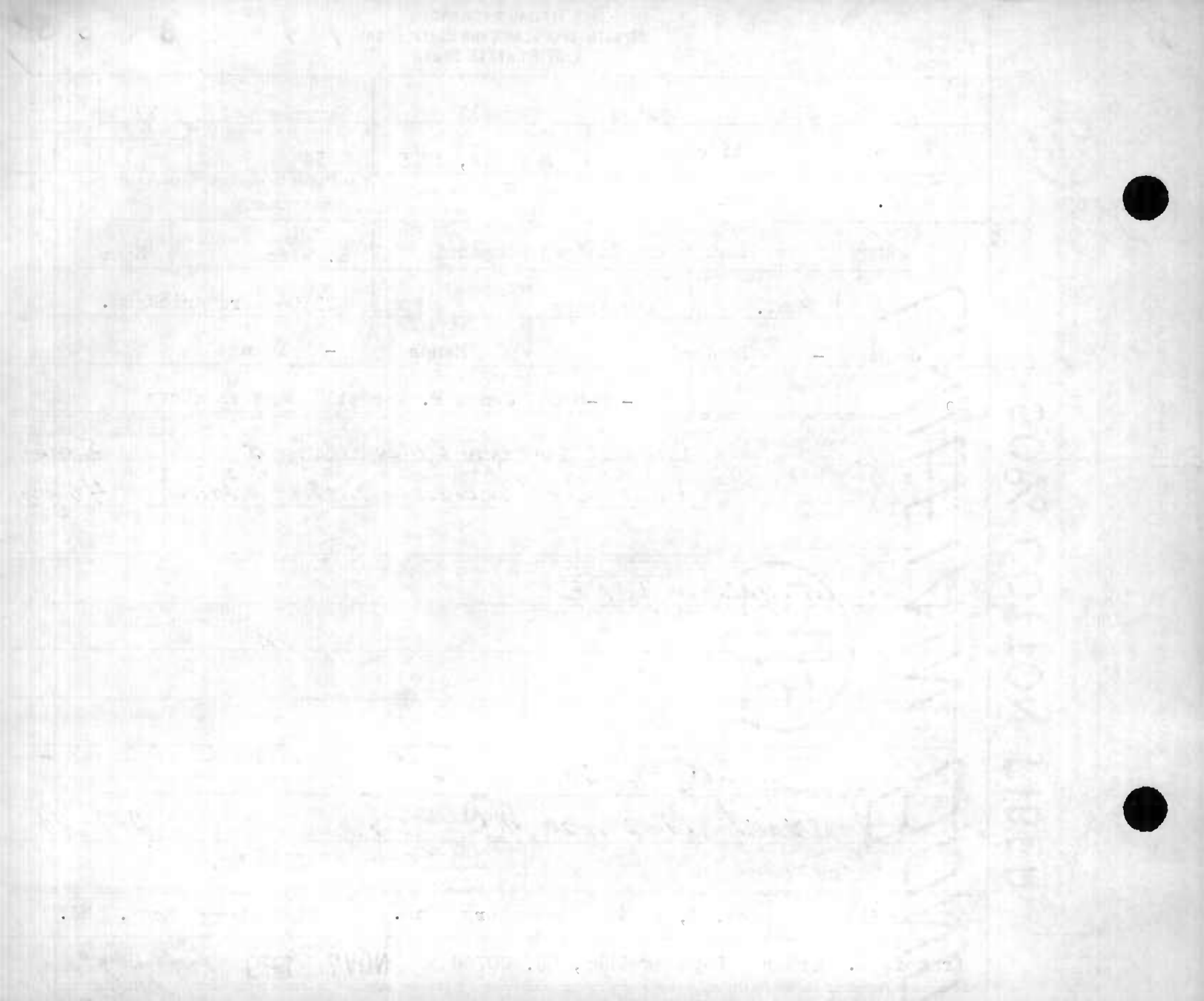
1. DECEASED NAME (TYPE OR PRINT) <b>Ella Louise Cordell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 1, 1979</b>			2b. HOUR <b>2:20PM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 14, 1925</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 74 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H. Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Clarksburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>23506 Frederick Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jess - Goddard</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude - Young</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-20-0406</b>		17. INFORMANT ADDRESS <b>James D. Cordell Same as above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus - massive CVA</b> 3940 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chn. Heart Disease - mitral stenosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chn. bronchitis &amp; COPE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 wks.</b> <b>40 yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>Nov. 1, 1979</b> , that (I) (we) last saw the deceased alive on <b>Oct. 31, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>Frederick Moomau, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-1-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederick Moomau, M. D.</b>						22e. ADDRESS <b>18111 Prince Philip Dr. Olney, MD 20832</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clarksburg Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clarksburg Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis H. Barber Laytonsville, Md. 20760</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony A. Brady</b>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 6 6			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Paul E Cotton				11/1/79				2A M			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
MALE		WHITE		6 8 27		52		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WASHINGTON, D. C.		U.S.A.				Montgomery				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital				NASA					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?				13c. STREET ADDRESS			
13a. STATE MARYLAND				13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13c. 10819 HOB NAIL COURT			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
JAMES L. COTTON				MARY CATHERINE MALONEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
YES				WW II		ROSEMARY M. COTTON		SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) CARCINOMATOSIS				1YR 3 MOS							
1890				DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) RENAL CELL CARCINOMA							
				DUE TO, OR AS A CONSEQUENCE OF							
				(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
INFECTOR VENACAVA THROMBOSIS PULMONARY THROMBOSIS											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Sept 19 79 to Jan 7 1980, that (1) (we) lost saw the deceased alive on Oct 31 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
C. DAVID SPENCER MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				11/1/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
C. DAVID SPENCER MD				10500 Summit Ave, Kensington, Md.							
23a. BURIAL, CREMATION, REMOVAL (STATE)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL				11/5/79		ARLINGTON NATIONAL		ARLINGTON		VIRGINIA	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS				NOV 2 1979				F. J. Collins			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G538 12/31/79 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28367	
1. DECEASED NAME (TYPE OR PRINT) Dorothy Alice Counts						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 26 19 79				2b. HOUR M 12:15	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 21 09		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 11 27 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 276 New Mark Esplanade				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 276 New Mark Esplanade	
14. FATHER'S NAME FIRST MIDDLE LAST James Gascoign						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Shaw					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT ADDRESS Walter B. Counts Same as Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 486- IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>						TITLE (SPECIFY) Assistant		DATE SIGNED 11/27/79		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 11/29/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crem.				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.	
24. FUNERAL DIRECTOR NAME W.W. Chambers						ADDRESS 8655 Ga. Ave.		25a. DATE REC'D. BY REGISTRAR DEC 03 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>MARJORIE D. CREECY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 8 1979</b>			2b. HOUR <b>p.m.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 6 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12604 Montclair Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STREET ADDRESS <b>12604 Montclair Dr. SS Md.</b>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward R. Deiteimeier</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Stand</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>579 26 9688</b>		17. INFORMANT ADDRESS <b>Wm. E. Creecy, 12604 Montclair Dr.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Small Cell Bronchogenic Carcinoma</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Disseminated Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>2 mos</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>Sept 12</b> , 19 <b>79</b> , to <b>Nov 8</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>Nov 3</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Hubert J. Alpert</b>						DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-9-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hubert J. Alpert M.D.</b>						22e. ADDRESS <b>8630 PENTON ST #230 Silver Spring MD 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 12, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>First Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore P.D. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Takoma Funeral Home 254 Carroll Rd NW</b>						25a. DATE FILED BY REGISTRAR <b>NOV 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Mary McCreedy</b>	

MEDICAL CERTIFICATION





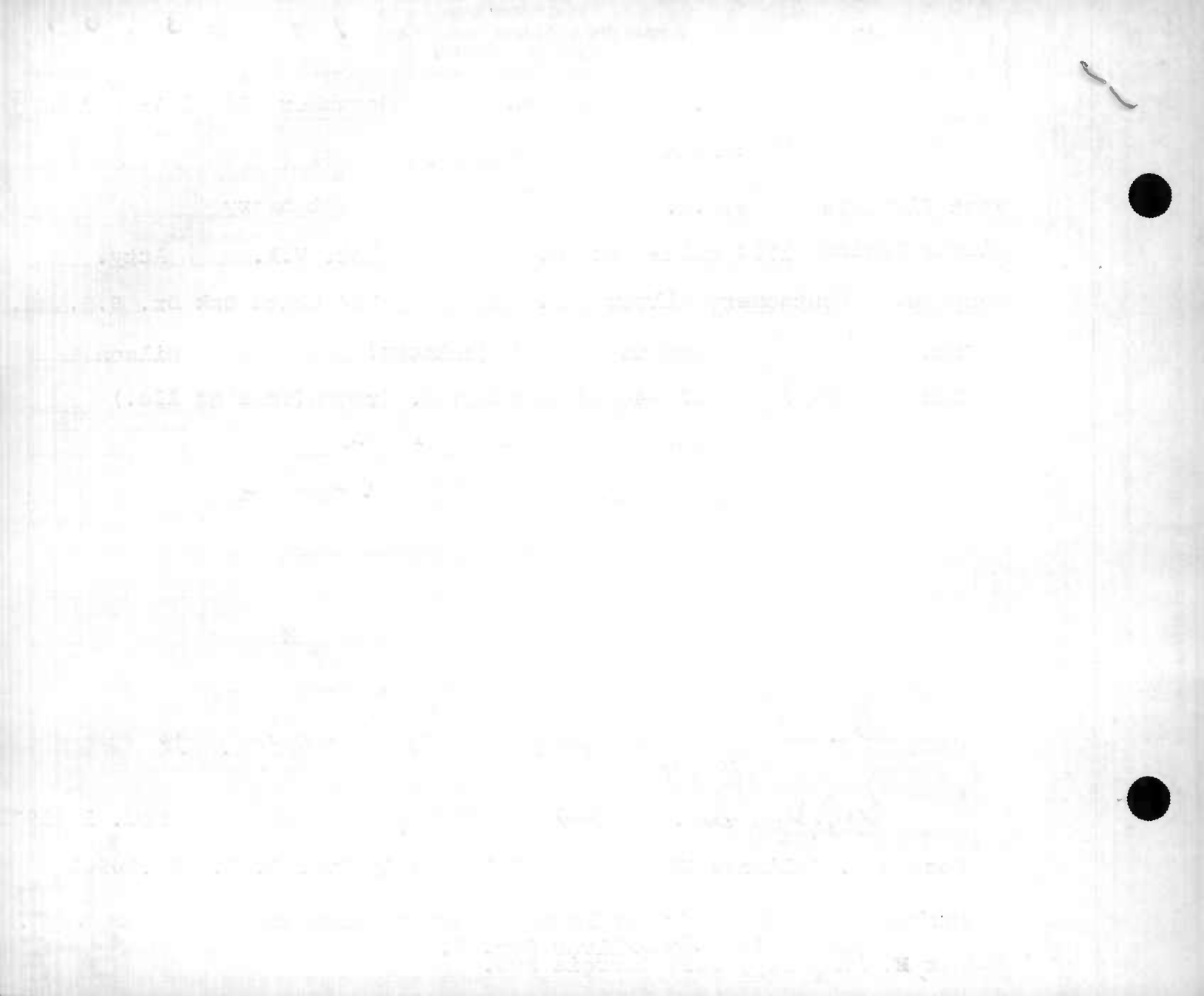


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>John D. Crogan</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 30, 1979</b>				2b. HOUR <b>11:15</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 18, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1704 White Oak Dr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. V.A.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Atty.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spr.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1704 White Oak Dr. S.S., Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Crogan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(unknown) Wilson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW 1</b>		17. INFORMANT ADDRESS <b>Rosalyn D. Crogan (same as 13e.)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiovascular collapse</b> <b>4/4/79</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>severe coronary artery disease -</b> (c) <b>due to, or as a consequence of</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1979</b> , to <b>11/30</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/28/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph M. Solinas</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>Dec. 1, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph M. Solinas, MD</b>				22e. ADDRESS <b>9801 Georgia Ave. S. S., Md. 20902</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-5-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kingwood West. Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, 8434 Georgia Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>notary M. C. Brady</b>			

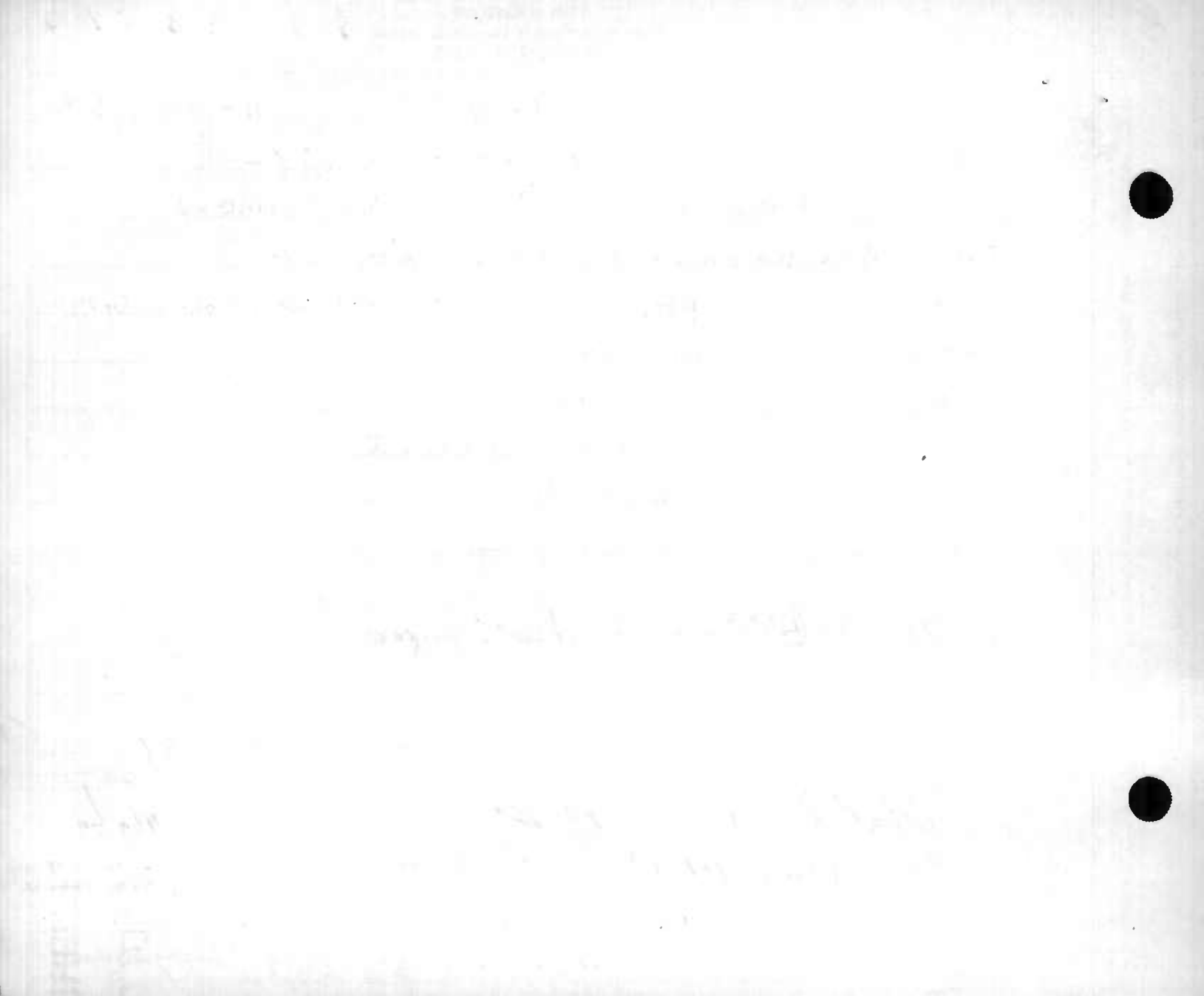


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		7 9 2 8 3 7 0															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JULIA		E				DABBS		11-17-79						6:00 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
FEMALE		CAUCASIAN		1 19 1900		79-YRS		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
D.C.		AMERICA				MONTGOMERY											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		HOUSEWIFE													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
MD.				D.C.				9014 Rhode Island Ave									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
LOUISE		UNK		NO		577-24-669		Donald Dabbs (Son)		13007 Elkridge St.							
										Beltsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>2506</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
11/1/79		Amputation for diabetic gangrene		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-19</u> , 19 <u>79</u> , to <u>11-17</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11-17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
Allan Gair M.D.		M.D.				11/17/79											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Allan Gair M.D.		11700 Old Columbia Pk Silver Spring Md.		Burial		11/20/79		Gate of Heaven Cemetery		S.S.		Mont.		Md.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md		NOV 21 1979		Hines/Rinaldi													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										9 2 8 3 7 1	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. HOUR		2c. DATE PRONOUNCED DEAD	
FIRST MARY, MIDDLE LEE, LAST DANA.						11-29-79		7 PM		11-29-79	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
F		W.		Jan. 30, 1917		62 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Mississippi		USA		WIDOWED XX						Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		10320 Westlake Dr.				Ret. Med. Librarian		HEW			
13a. STATE											
Md.											
13b. COUNTY											
Montg.											
13c. CITY OR TOWN											
Bethesda											
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
13e. STREET ADDRESS											
10320 Westlake Dr.											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST						FIRST MIDDLE LAST					
Robert E. Lee						Ina Felder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.					
No						428 07 1174					
17. INFORMANT						3102 Mogford					
Roberta Rhodes						Midland, Texas					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Acute + Chronic Alcoholism</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
John G. Ball				M.D. Deputy				Dec 1, 1979			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				BETHESDA, Md.			
John G. Ball				7936 Old Georgetown Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Cremation				Dec. 3, 1979				Metropolitan Crem.			
23d. LOCATION CITY OR TOWN				COUNTY				STATE			
Alexandria, Va.											
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A.				DEC 6 1979				Anthony McBrady			
ADDRESS								Bethesda, Md.			

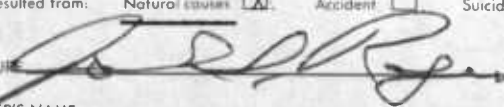
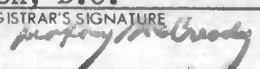
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FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

Belmont, J. Edgar  
1033 Vermont St.  
Washington, D. C.  
Robert, J.  
1033 Vermont St.  
Washington, D. C.

James, A. A.  
Robert, J.  
1033 Vermont St.  
Washington, D. C.  
John, F. Sullivan  
7015 Old Georgetown Rd.  
Bethesda, Md.  
Alexander, J. M.  
1033 Vermont St.  
Washington, D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28372			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma B. Daniels										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Nov. 24, 1979		2b. HOUR OF DEATH 6:00 A.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 29, 1907		6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD November 24, 1979		2d. HOUR 1:25 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7051 Carroll Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Takoma Park										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7051 Carroll Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob - Bruegger						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna - Siebert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Ernest Bruegger				ADDRESS 248 Oak Rd. Arnold, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 11/26/79	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Rd. Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE Nov/26/79		23c. NAME OF CEMETERY OR CREMATORY Georgetown Medical School				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home						ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 30 1979		25b. REGISTRAR'S SIGNATURE 			



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U.S. AIR FORCE  
HEADQUARTERS  
AIR FORCE  
WASHINGTON, D.C.

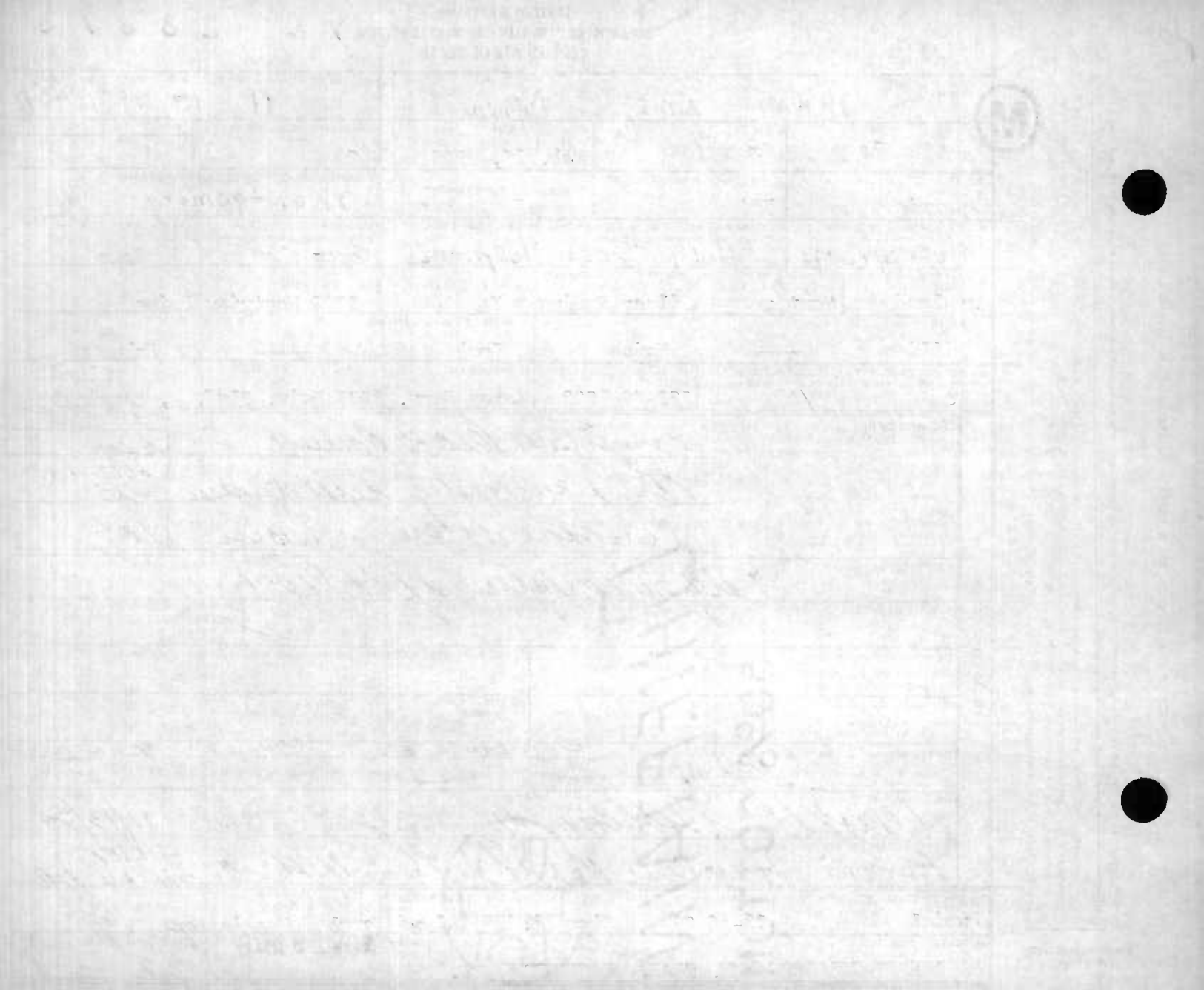


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 7 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary NMI DANN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 13 79</b>		2b. HOUR <b>4:45 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 15, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Springs</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>2305 Westview Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Weiss</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Maryland Kensington</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mos. to 4 yrs.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Pathy in Montgomery of 10/1/78</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/1/78</b> 19 <b>68</b> , to <b>10/13</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>10/13</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Albert H. Grollman MD</b>				DEGREE <b>MD</b>		22c. DATES SIGNED <b>11/13/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT H. GROLLMAN</b>				22e. ADDRESS <b>1106 SPRING ST. SILVER SPRING MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-15-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ohev Sholom Talmud Torah</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEM. CHAP., ROCKVILLE, MD.</b>				25a. DATE OF REGISTRATION <b>NOV 15 1979</b>			



LRE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mario Dias Domingues da Silva</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 12, 1979</b>		2b. HOUR A <b>9:30 M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 3, 1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Brazil</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Brazil</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, Bethesda, Md. 20205</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Military Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Brazil</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>D. C.</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lauro Domingues da Silva</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etelvina Dias Domingues da Silva</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Col. Agisse Bahia, Brazilian Embassy.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis with shock, cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gram negative pneumonia, septic emboli</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pseudomonas urinary infection</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>5 days</b> <b>3 weeks</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Systemic amyloidosis, acute renal failure, hepatic failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 9, 1979</b> to <b>November 12, 1979</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 12, 1979</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <b>Joseph R. McClellan MD</b>				22c. DATE SIGNED <b>Nov. 12, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph R. McClellan</b>				22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial/Removal</b>		23b. DATE <b>Nov. 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>S. Joad Baptista Cem.</b>	
23d. LOCATION CITY OR TOWN <b>Rio de Janeiro</b>		23e. STATE <b>Brazil</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> NAME ADDRESS <b>5130 Wisconsin Ave., N.W. Wash. D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>	



From: [illegible] To: [illegible]

Subject: [illegible]

[illegible text]

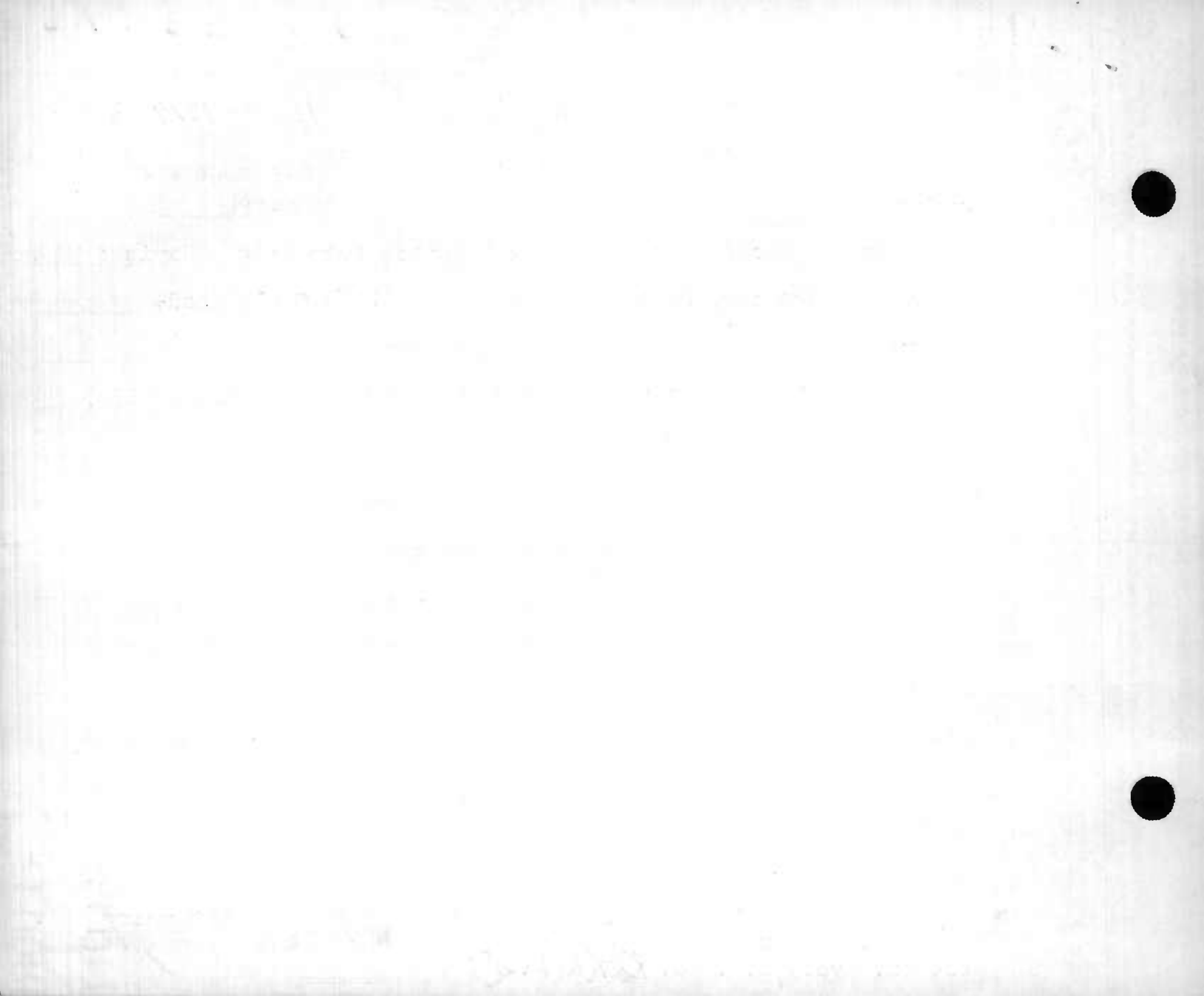
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 3 7 5	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Francis Elwood Davis</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>11-8-1979</i>				2b. HOUR <i>2:45 A.M.</i>		
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 26 1924</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Auto Body</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Davis &amp; Wilson</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Wheaton</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>12718 Gould Road,</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benard Davis</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>(unknown)</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT ADDRESS <i>Terry Lee Davis-son-(same as 13e)</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>GI Bleeding</i> <i>5715</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Renal Failure</i>											
19a. DATE OF OPERATION <i>Oct 18, 1979</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>GI Bleeding</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 16</i> , 19 <i>79</i> , to <i>11-8</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11-7</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If none read) (did not view the body after death)											
22b. SIGNATURE <i>Michael R. Becken</i>					DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <i>11-8-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael R. Becken</i>					22e. ADDRESS <i>1109 Spring St Silver Spring Md</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>11-10-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Montgomery Md.</i>			
24. FUNERAL HOME (NAME) <i>Walter E. Pumphrey, Inc.</i>					25a. DATE <i>NOV 18 1979</i>					25b. REGISTRAR'S SIGNATURE <i>John J. McCreedy</i>	
8434 Ga. Ave., S.S. Md. <i>Kathleen</i>											



1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Genevieve M. Davis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 10, 1979</b>			2b. HOUR <b>5:40a<sub>M</sub></b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 7 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4100 Queen Mary Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stanley</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(unknown) Andewczyk</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>		17. INFORMANT ADDRESS <b>Thomas J. Davis-son-4601 Beltswood D Olney, Md. 20832</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 431- DUE TO, OR AS A CONSEQUENCE OF, <b>ACTERIO SCLEROSIS</b> yrs - b) <b>HYPERTENSION</b> yrs - c) <b>HYPERTENSION</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <b>4/15/73</b> to <b>11/10/79</b> that (1) was last seen alive on <b>11/10/79</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) the (1) did not have the body after death.										
22b. SIGNATURE <b>D. R. Lewis MD</b>			DEGREE <b>MD</b>			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/10/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. R. LEWIS MD</b>			22e. ADDRESS <b>OLNEY, MD 20832</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-13-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>			
24. FUNERAL DIRECTOR <b>Walter E. Pumphrey, Inc.</b> <b>8434 Ga. Ave., S.S. Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL

NAME	GRADE	COMPONENT	BRANCH	STATUS
JOHN A. SMITH	1ST LT	1ST INF	ARMY	ACTIVE
JAMES H. BROWN	2ND LT	2ND INF	ARMY	ACTIVE
WILLIAM C. JONES	3RD LT	3RD INF	ARMY	ACTIVE
CHARLES E. WHITE	4TH LT	4TH INF	ARMY	ACTIVE
HENRY D. BLACK	5TH LT	5TH INF	ARMY	ACTIVE
FRANK G. GREEN	6TH LT	6TH INF	ARMY	ACTIVE
EDWARD F. HARRIS	7TH LT	7TH INF	ARMY	ACTIVE
ROBERT L. KING	8TH LT	8TH INF	ARMY	ACTIVE
ALFRED M. LEE	9TH LT	9TH INF	ARMY	ACTIVE
WALTER N. PEARSON	10TH LT	10TH INF	ARMY	ACTIVE

JOHN A. SMITH  
1ST LT  
1ST INF  
ARMY  
ACTIVE

WALTER N. PEARSON  
10TH LT  
10TH INF  
ARMY  
ACTIVE



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sara Ann Davis</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>14</b> YEAR <b>79</b>		2b. HOUR <b>5:15 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>28</b> YEAR <b>1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b>	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Mont</b> MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maid</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Langley</b>	13c. CITY OR TOWN	
14. FATHER'S NAME FIRST <b>Charlie</b> MIDDLE <b>Poindexter</b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>Flora</b> MIDDLE <b>Markin</b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>223 22 0577</b>		17. INFORMANT ADDRESS <b>Jasper Davis-Husband-8206 New Hampshire Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alveolar-cell carcinoma, right lung, with</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastases to brain and liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 mos.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>					
19a. DATE OF OPERATION <b>June 1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Above</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 6</b> , 19 <b>79</b> , to <b>Nov. 14</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William F. Simpson, MD</b>				22c. DATE SIGNED <b>11/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William F. Simpson, MD</b>				22e. ADDRESS <b>8106 N.H. Ave, Silv. Spr. Md 20905</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/79</b>		23c. LOCATION CITY OR TOWN COUNTY STATE <b>Fort Lincoln Cemetery, Brentwood, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Stewart Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McHenry</b>	



RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eugene de Bor			2a. DATE OF DEATH MONTH DAY YEAR November 30, 1979			2b. HOUR 12:40 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Brookmont		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6424 Broad Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Geodesist		12b. KIND OF BUSINESS OR INDUSTRY Army Map Ser.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Brookmont		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6424 Broad Street	
14. FATHER'S NAME FIRST MIDDLE LAST John De Bor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ilona Racz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 168-28-0986		17. INFORMANT ADDRESS Wife - Clara de Bor - Same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1539

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 week

4 months

19-20 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-22-79 to 11-30-79, that (I) (we) last saw the deceased alive on 11-22-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Russell M. Tilley, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-30-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley, M.D.		22e. ADDRESS 4701 Mass. Ave., N.W., Wash. D.C.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-3-79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek, Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home Washington, D.C.				25a. DATE REC'D. BY REGISTRAR DEC 7 1979			
25b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

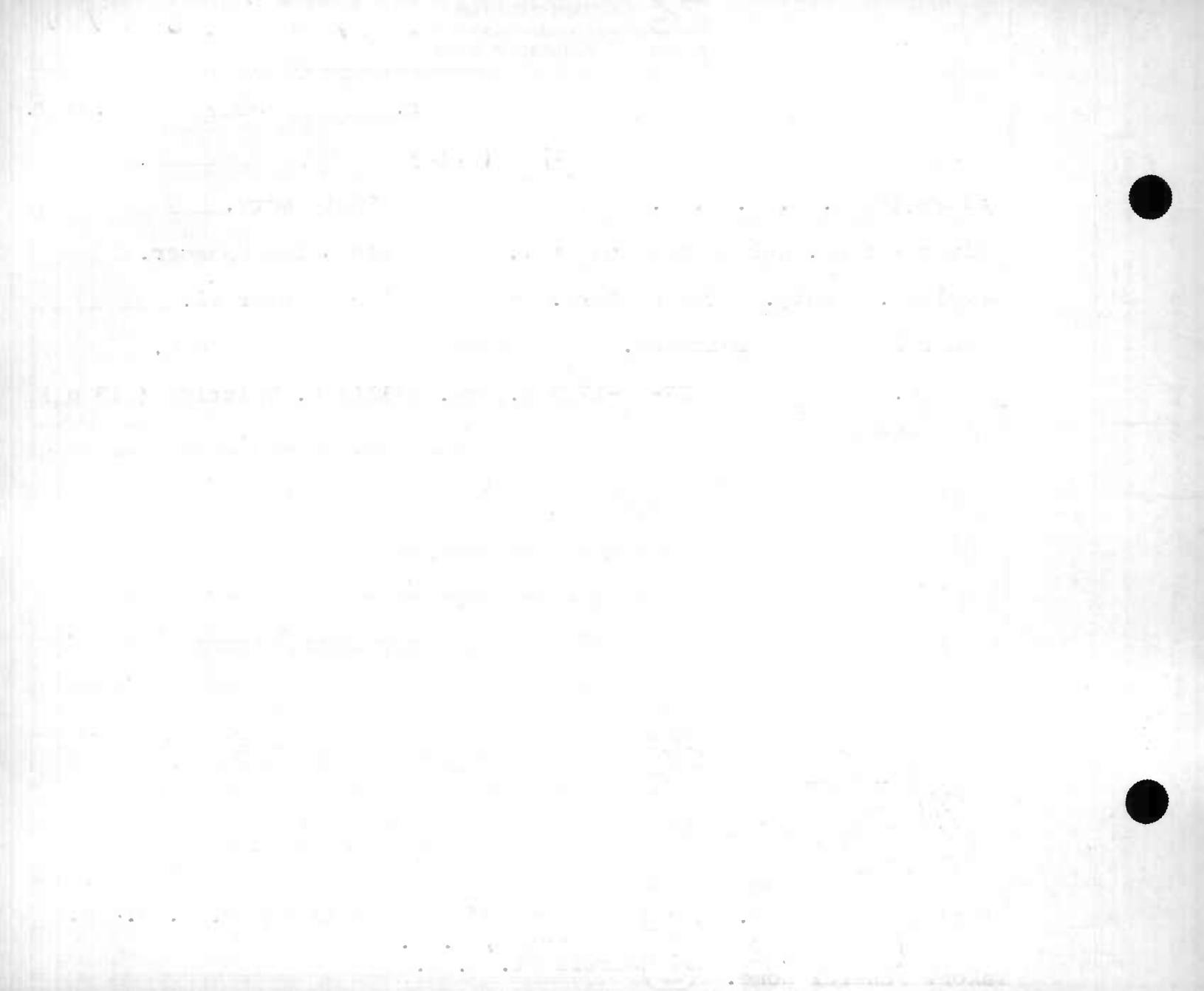
TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 7 9 2 8 3 7 9						
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR
Woodard S.			Deitrick Sr.			11-29-79			8:30 PM
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS	
male	w	5-21-03		76 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Washington D. C.	U. S. A.				Montgomery, MD.				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring.	Holy Cross Hospital.				Auto Sales Manager.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a STATE Maryland.			Montg.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7229 Minter Pl.		
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Samuel Deitrick.			Clara Pope.						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
No.			577-10-1723		A. Mrs. Tillie C. Deitrick (13 e)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4392 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease with Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of Bladder with metastases									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 19 65, to Nov 29 19 79, that (I) (we) last saw the deceased alive on 11-29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
Morton Altschuler MD							11/29/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Morton Altschuler MD					1295 - CAMBESANTON DRIVE Silver Spring, Md. 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Dec. 3, 1979		Cedar Hill		Suitland Rd. P. Md. Co.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. Arthur Walters		Washington, D. C.		W. DEC 5 1979		Anthony McCreedy			
Takoma Funeral Home		254 Carroll St. N.							



BH

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 8 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
MARIA DO CARMO MOREIRA DE SOUZA			NOVEMBER 9, 1979			4:30 pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE	WHITE	JUNE 22 1939	40 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
BRAZIL	BRAZIL		MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	THE CLINICAL CENTER		PHYSICIAN			MEDICAL		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			MONTGOMERY			ROCKVILLE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS		
ADAUTO JOSE MOREIRA			MARIA RODRIGUES BORGES			20852 397 CONGRESSIONAL LANE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			NONE			579-98-5609 MR. JOSE MARTINS DE SOUZA (HUSBAND)		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SUB ARACHNOID HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>BERRY ANEURYSM</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>SYSTEMIC LUPUS ERYTHEMATOSUS</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>OCTOBER 26, 1979</u> , to <u>NOVEMBER 9, 1979</u> , that (we) last saw the deceased alive on <u>NOVEMBER 9, 1979</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Robert M. Lester, MD</u>						<u>11/9/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
<u>ROBERT M. LESTER MD</u>			<u>NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
<u>BURIAL</u>		<u>NOV/16/79</u>		<u>GOANIA CEMETERY</u>		<u>GOANIA, BRAZIL</u>		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>CHAMBERS FUNERAL HOME RIVERDALE, MARYLAND</u>				<u>NOV 14 1979</u>		<u>Pietro/Alberty</u>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*Handwritten signature or initials.*

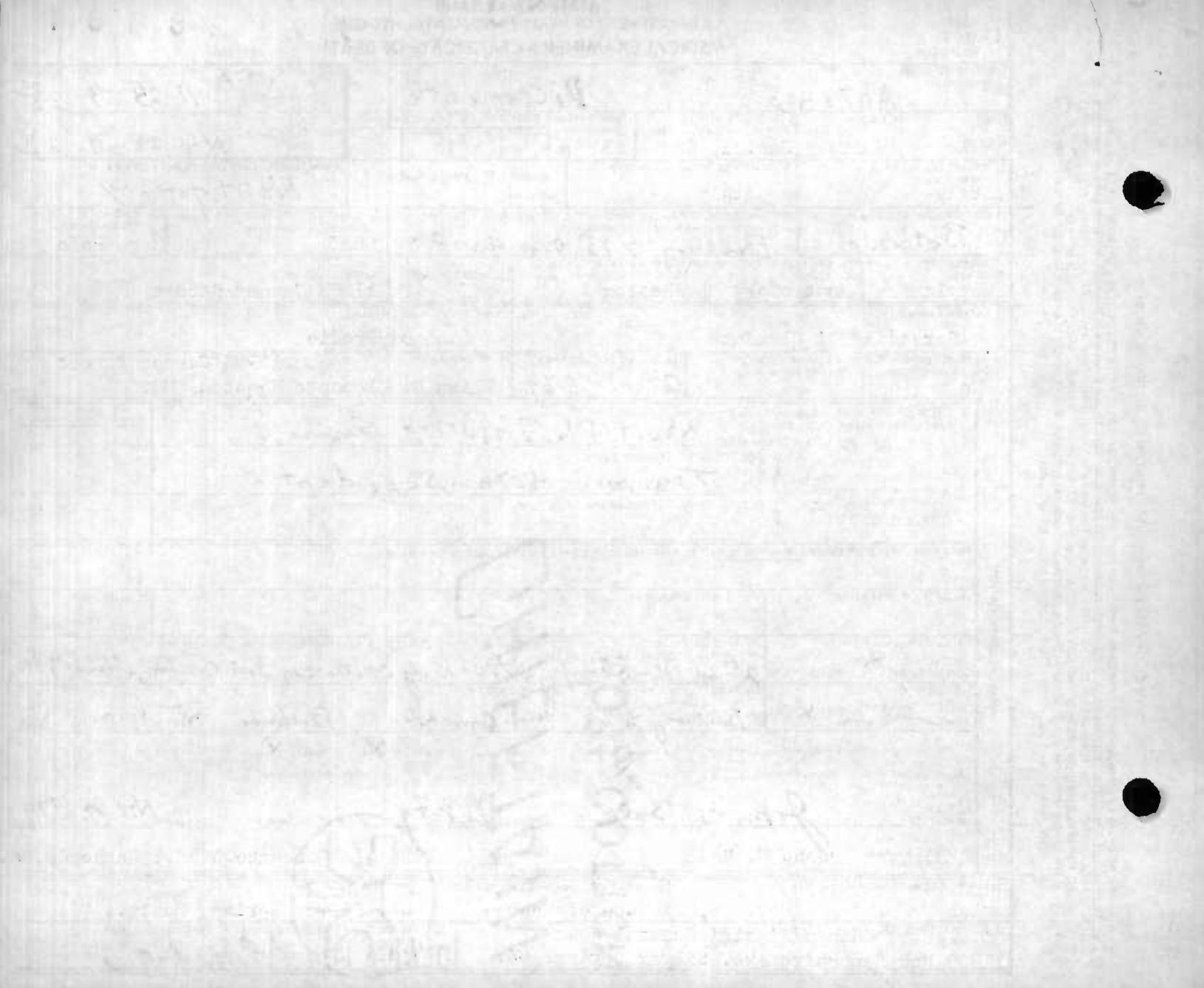
NOV 2 1952

RECEIVED



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE SALE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28381			
1. DECEASED NAME (TYPE OR PRINT) <b>Antonio DiClemente</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11-25 1979</b>		2b. HOUR <b>2:30 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 1, 45</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>34 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov. 25 1979</b>		2d. HOUR <b>2 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>				7b. CITIZEN OF WHAT COUNTRY? <b>Italy</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda 495 Penn. Comm. Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chef</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Maro Polo</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11908 Garner Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernadino Di Clemente</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Di Profio</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-78-8069</b>		17. INFORMANT <b>11908S Garner Street Elisa Di Clemente Wheaton, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE INJURIES SEVERE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Trauma - Auto. Accident.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:30 AM 11-25 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Struck by another car lost control, Struck by Tree</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Bethesda 495 Penn. Comm. Ave.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Bethesda Montgomery Md</b>							
22a. I certify that I took charge of the remains described above, held on										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>Nov 25, 1979</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>				ADDRESS <b>7936 Old Gerogetown Rd., Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 28, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Montg., Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 03 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert K. B...</b>					

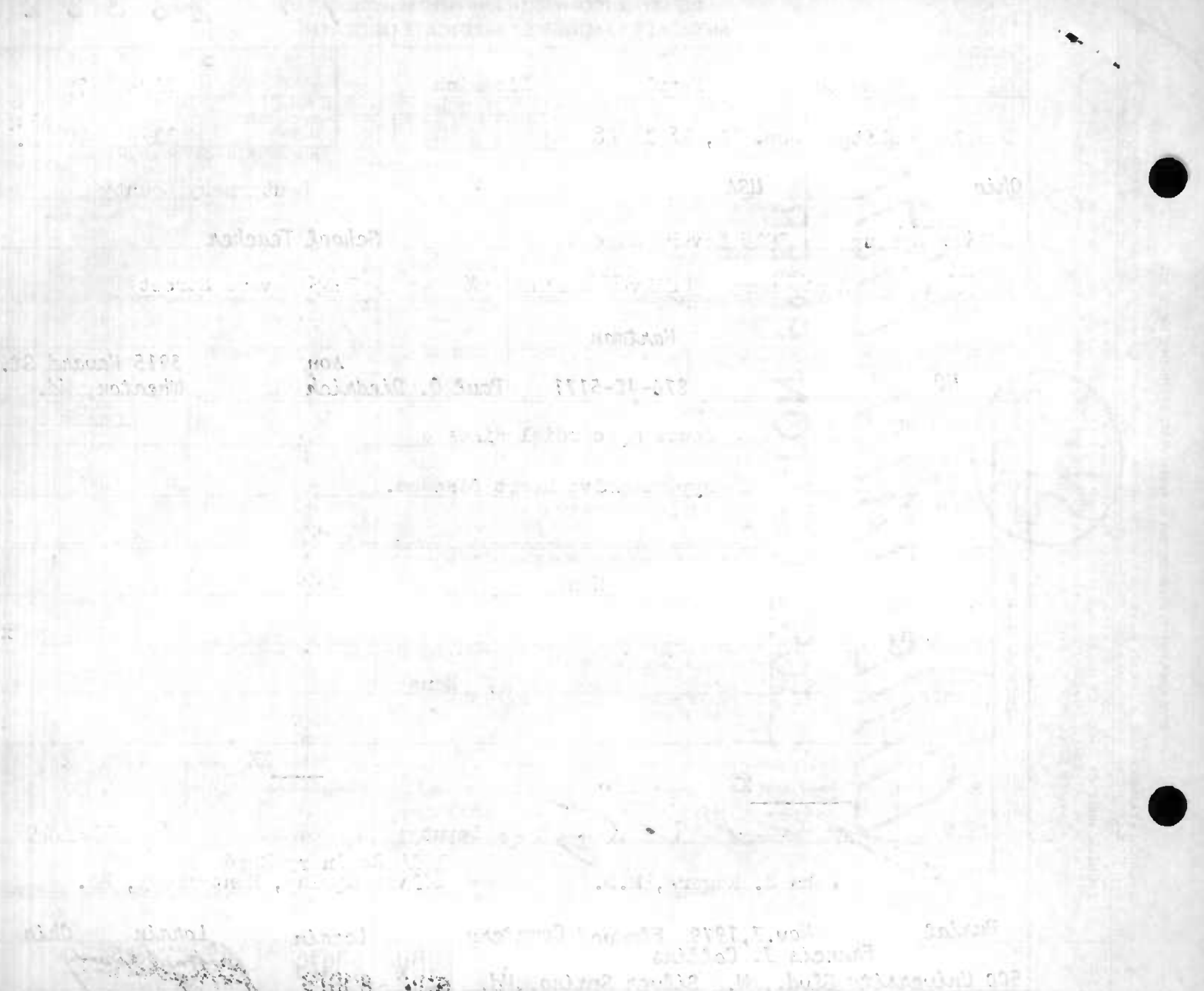


BP  
DHMH-17  
(VR A15 ME (5))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 8 2			
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										7b. HOUR			
FIRST MIDDLE LAST Edith Pearl Diedrich										MONTH DAY YEAR 11/4 1979										M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR								
Female		White		Sep. 11, 1891			88 YRS.		MONTHS DAYS		HOURS MIN		11/4 1979		11:50 P. M.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Ohio				USA								Montgomery County MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
WHEATON				3915 Havard Street				School Teacher															
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
OHIO				LORAIN		GRAFTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3511 GRAFTON ROAD													
14. FATHER'S NAME FIRST MIDDLE LAST								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Hartman																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
NO				276-42-5171				son Paul O. Diedrich				3915 Havard St. Wheaton, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>hypertensive heart disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
None														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
								None															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy MEDICAL EXAMINER								DATE SIGNED 11/5/79											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
John S. Rogers, M.D.				1919 Seminary Road Silver Spring, Montgomery, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial				Nov. 7, 1979		Elmwood Cemetery				Lorain Lorain Ohio													
24. FUNERAL DIRECTOR NAME				ADDRESS				DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Francis J. Collins				500 University Blvd., W. Silver Spring, Md.				NOV 8 1979				[Signature]											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPHINE		MIDDLE		LAST DILIBERTO		2a. DATE OF DEATH MONTH DAY YEAR 11 11 79		2b. HOUR 10:40 AM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 6 15		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not known, give street address) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8805 Bellwood Road			
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas DeMarzo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Bellofatto		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 154 09 3173		17. INFORMANT ADDRESS 115 West 78th N.Y. N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>10/16</u> , 19 <u>79</u> , to <u>11/11</u> , 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>11/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (I) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>FOR DR. S. NEWMAN</u> ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/11/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Mehlman for Stephen Newman				22e. ADDRESS 5625 Bradley Blvd Bethesda Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/14/79		23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Orange, New Jersey					
24. FUNERAL DIRECTOR NAME ROBERT A. PUPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

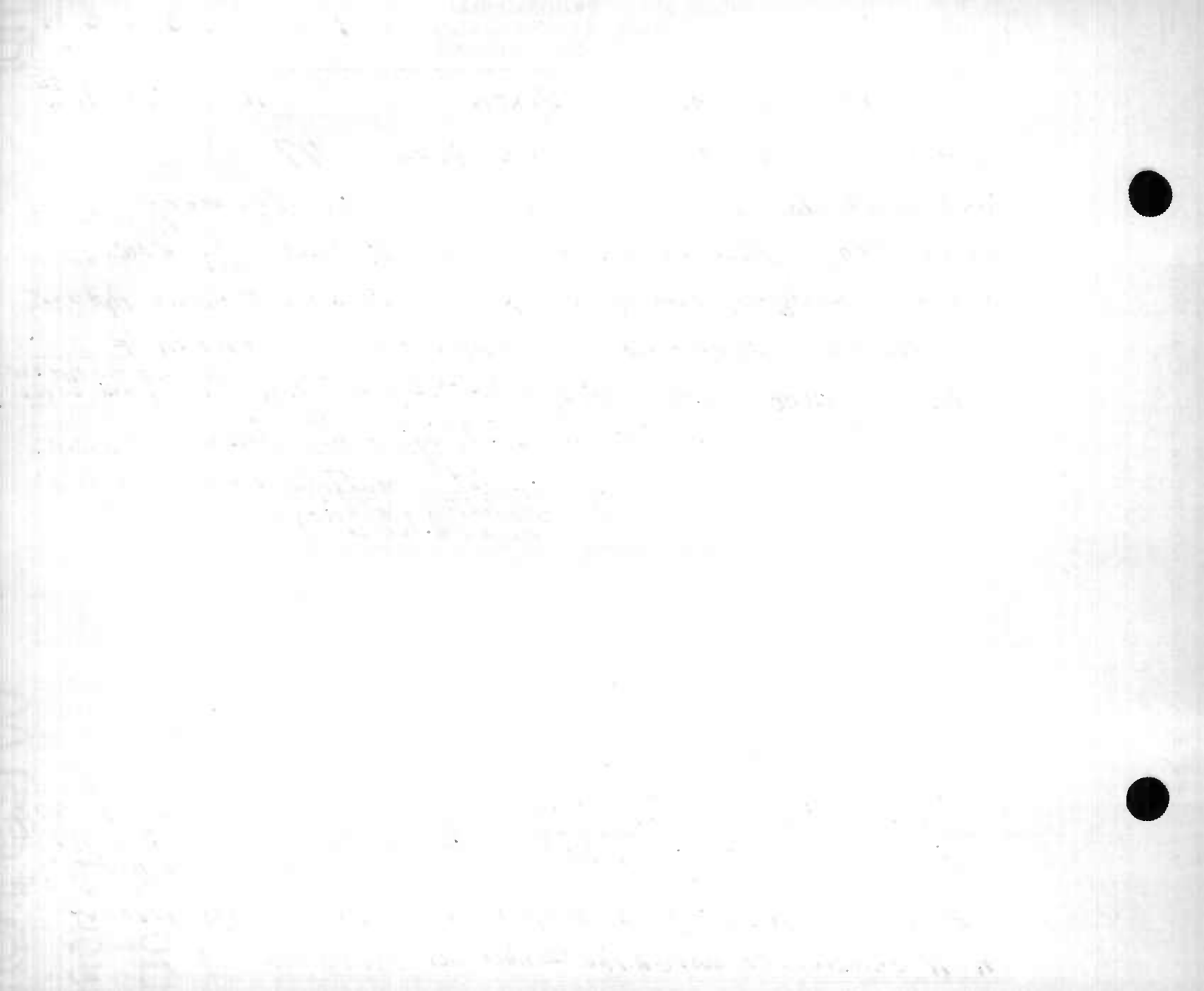
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PHOEBE M. DIXON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 2 79</b>			2b. HOUR <b>11 35</b> A.M.			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 6, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Brunswick Canada</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Nursing</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GMC</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS MICHAEL</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HARRIETT TARDIFF</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT NAME ADDRESS <b>Mr. Keith D. Dixon son 3028 Hewitt Ave Apt 235 Silver Spring Md. 20906</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic respiratory-cardiac failure</b> <b>4289</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>aging, senility &amp; multiple long-standing pathologic changes.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 2, 1979</b> to <b>Nov. 2, 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov 2, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Donald W. Datlow</b> DEGREE <b>DONALD W. DATLOW, MD</b>						22c. DATE SIGNED <b>Nov 2, 1979</b>		22d. ADDRESS <b>823 University Blvd. West Silver Spring, Md. 20901</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>Nov 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Joseph Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bristol Connecticut</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>W. W. Chambers Co. 8655 GA. Ave SS Md 20910</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 05 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Hutney/McBride</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethna H. Donnally					2a DATE OF DEATH MONTH DAY YEAR November 14, 1979			2b HOUR 8:55 AM		
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 18, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Donald S. Hunter					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Black					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 076-22-6677		17 INFORMANT Andrew V. Donnally		ADDRESS 7801 Norfolk Ave. Bethesda, Md.				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>79</u> , to <u>11/14</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>K. Shym</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/14/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirk E. Flury M.D.				22e. ADDRESS 9410 Old Georgetown Rd. Bethesda, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 17, 1979		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.				
24. FUNERAL DIRECTOR NAME Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE				

000 BP



Female	Concession	Apr. 18, 1920	33	
Male	USA			
Not used	Shut in			
Housewife	House			
Mr.	Monte.	Rockville	X	4 Monroe St.
Donald	Hunter	Alain		
No	070-12-0077	Andrew V. Donnelly		7801 Kettling Ave. Bethesda, Md.

Nov. 17, 1929  
Robert A. Donnelly  
Funeral  
Homes, P.A.  
Bethesda, Md.

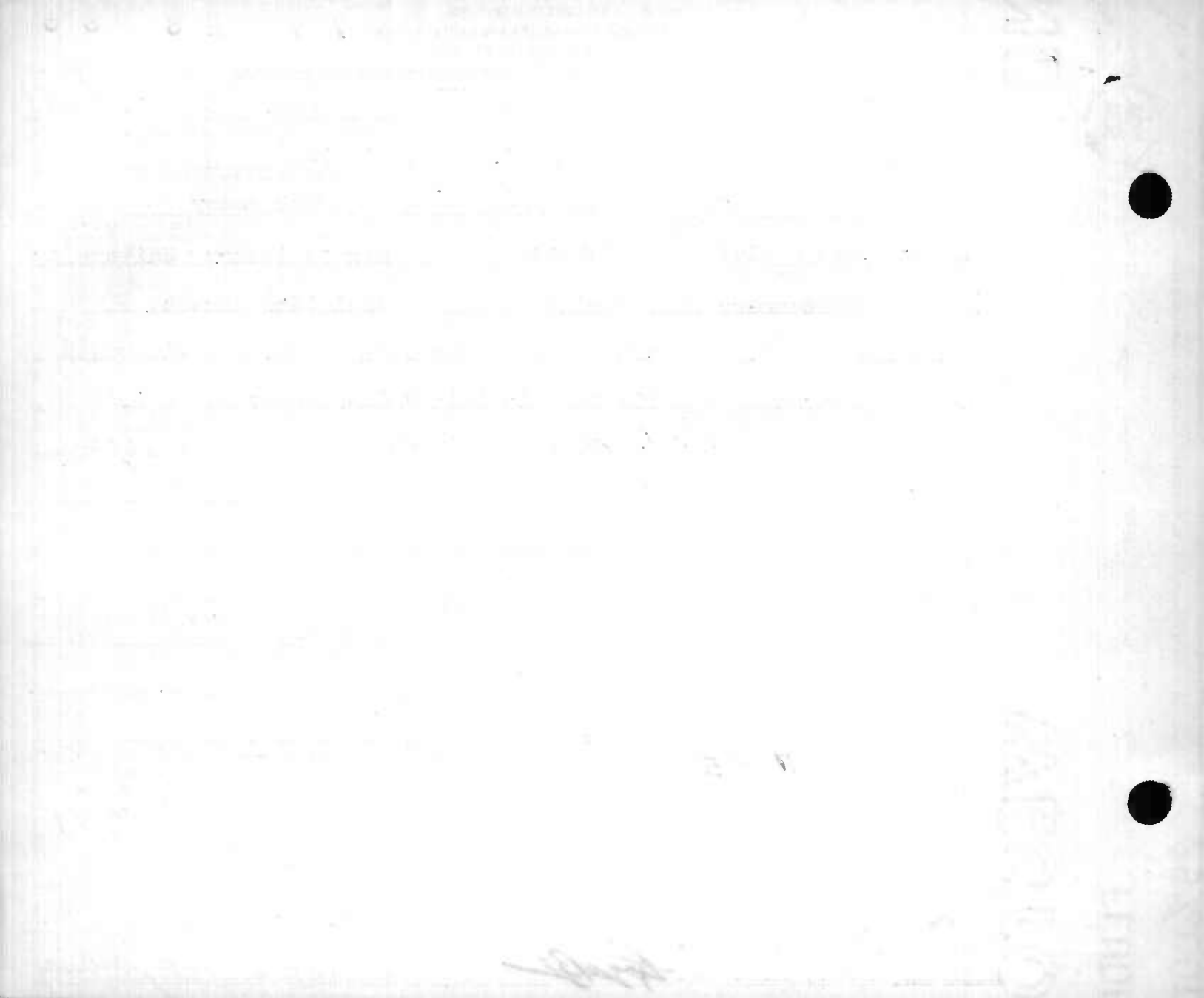
Nov. 17, 1929  
Robert A. Donnelly  
Funeral  
Homes, P.A.  
Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 3 8 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMMA DORSETT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 5 1979</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 10 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8201 16th Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Reg. Registrar</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Yale University</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spring</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William R. Park</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline M. Ainsworth</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Virginia Smith-dau-(same as 13c)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head Injury Dissection</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/10</b> 19 <b>79</b> to <b>4/5</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>4/5</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Myron L. Lenkin</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/6/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>				22e. ADDRESS <b>2389 SHOREFIELD RD WHEATON MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-6-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Fairfax Va.</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc</b> ADDRESS <b>8434 Ca. Ave., S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 08 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. Brady</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE / 9 2 8 3 8 7 CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <sup>0</sup> THALMY (Thamy) D. <sup>2</sup> DORSEY					2a. DATE OF DEATH MONTH DAY YEAR 11-6-79 2b. HOUR 9:46 PM				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR OCT. 8, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Cocksville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Millers Mill Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Prince Albert Dorsey					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marly L. Parker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -		17. INFORMANT Helen Holland		ADDRESS Cocksville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>OCCULT MALIGNANCY</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 10</u> , 19 <u>79</u> , to <u>NOV 6</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>above</u> , (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE <u>Pedro I. Matias</u> DEGREE <u>MD</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>NOV 7, 79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PEDRO I. MATIAS</u>					22e. ADDRESS <u>1811 Prince Philip Drive Olney Md</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11-9-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Taylor Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bushy Park, Howard Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Harry W. Haight</u> ADDRESS <u>Silverth, Md.</u>					25. DATE REC'D. BY REGISTRAR <u>NOV 13 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

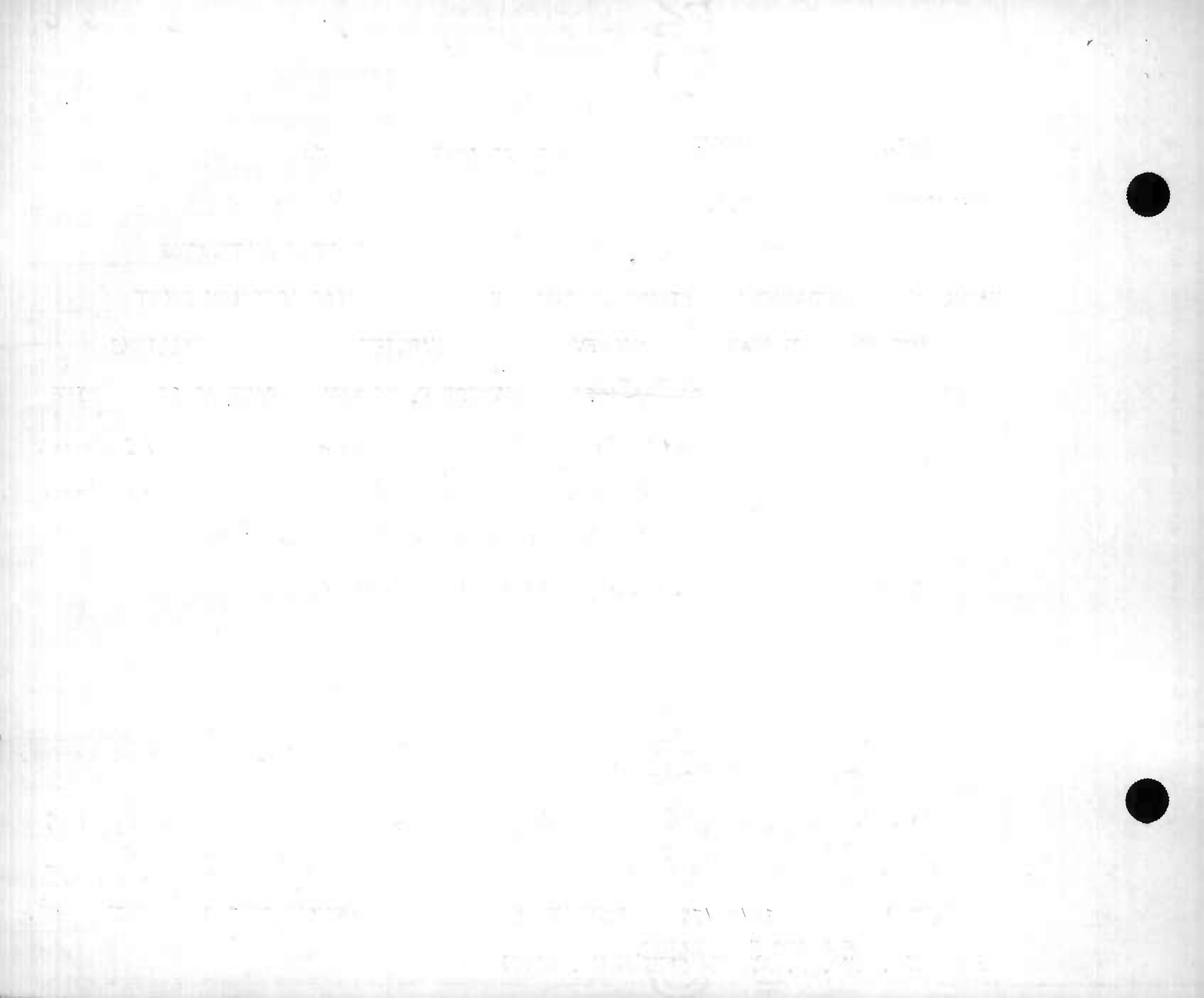
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Arthur T. Downey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 23 79</b>		2b. HOUR <b>9A</b> M								
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 21, 1905</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>74</b>		8. IF UNDER 24 HRS HOURS MIN. <b>9A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Silverspring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HEATING CONTRACTOR</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3114 ADDERLEY COURT</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ARTHUR THOMAS DOWNEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HARRIET WILLIAMS</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>066-05-0474</b>		17. INFORMANT <b>BEATRICE F. DOWNEY</b>				ADDRESS <b>SAME AS 13 WIFE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiogenic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myocardial infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b> <b>15 hours</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110: <b>Atherosclerotic coronary heart disease</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/9 1979</b> to <b>10/23 1979</b> , that (I) (we) last saw the deceased alive on <b>10/22 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Martin C. Shargel</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/23/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN C. SHARGEL</b>						22e. ADDRESS <b>3720 FARROBOUT AVE KANSINGTON MD 20795</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/25/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>					
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE RECD. BY REGISTRAR <b>OCT 30 1979</b>						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

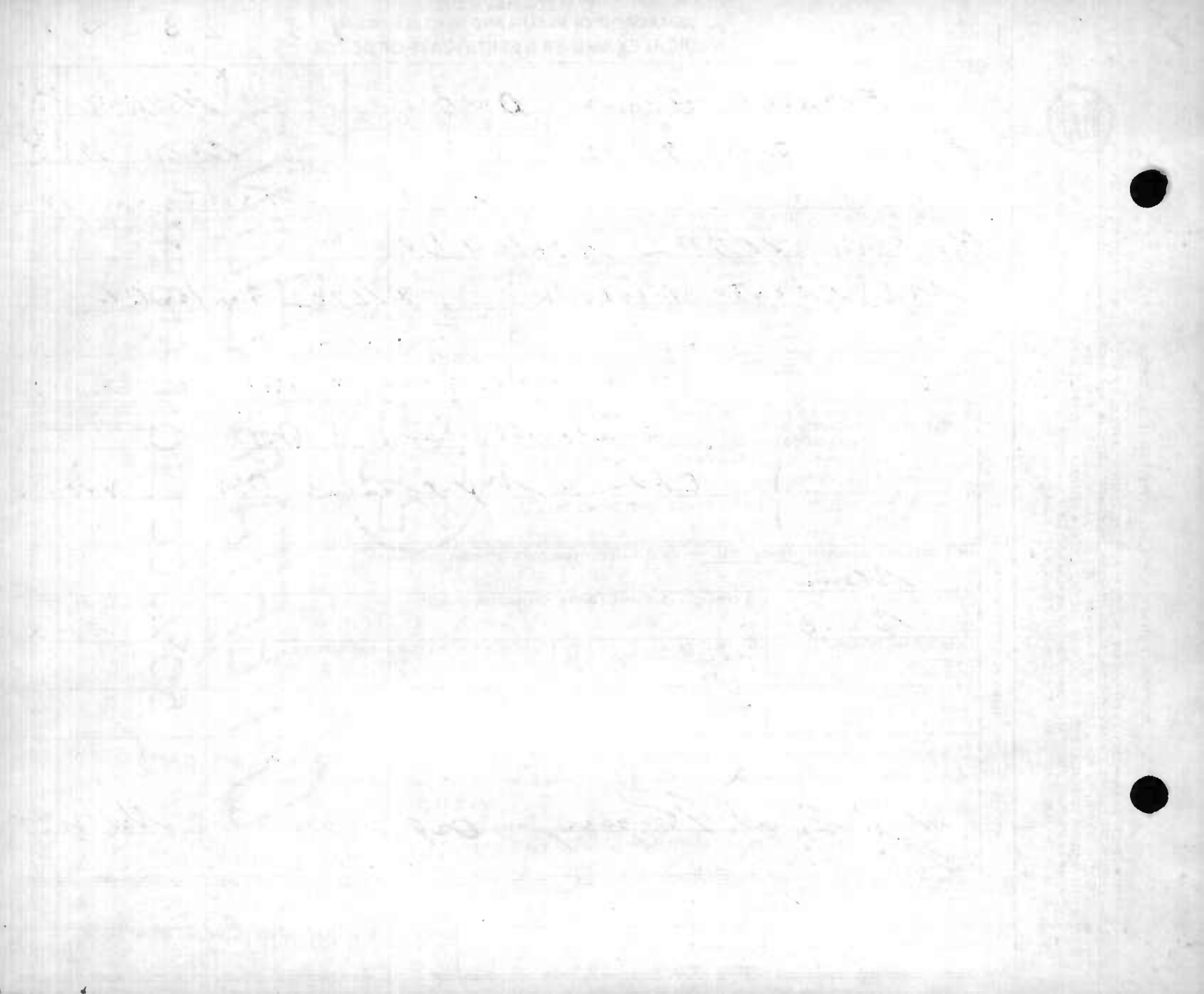
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 28389			
1. DECEASED NAME (TYPE OR PRINT) <b>Francis Brown DuBois</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>Nov 11 1979</b>		2b. HOUR <b>3:40</b> AM	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 27 1922</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>57</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>							
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11702 Ashley Dr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>MD</b>		13b. COUNTY <b>Montg</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>11702 Ashley Dr.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE B. DUBOIS SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCES M. BROWN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216 46 3573</b>		17. INFORMANT ADDRESS <b>GEORGE DUBOIS 9219 E PARK HILL DR.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>4291</b> (b) <b>Chronic Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Yrs.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>													
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>Dep.</b>				MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>				ADDRESS <b>1919 SEMINARY RD. S. S. MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>11-12-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>ALEX., VA</b>					
24. FUNERAL DIRECTOR NAME <b>VANN &amp; WILLIAMS</b> ADDRESS <b>4804 GA AVE NW.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							



1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert H. Dugert</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 6, 1979</b>			2b. HOUR <b>3:05P M</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 09 34</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TRADING</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>					13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY DUGERT</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA WEINGES</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>1956-1958</b>		17. INFORMANT <b>WIFE</b>		ADDRESS <b>SAME AS PATIENT</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEPATO-RENAL FAILURE</b> <b>5712</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CIRRHOSIS OF THE LIVER</b> (c) <b>PROLONGED CHRONIC ALCOHOLISM</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 25</b> , 19 <b>79</b> , to <b>Nov 6</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 6</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ruben C. Cosca, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-6-79.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RUBEN C. COSCA, M.D.</b>				22e. ADDRESS <b>17529 REDLAND ROAD, OAKWOOD, MD 21115</b>			

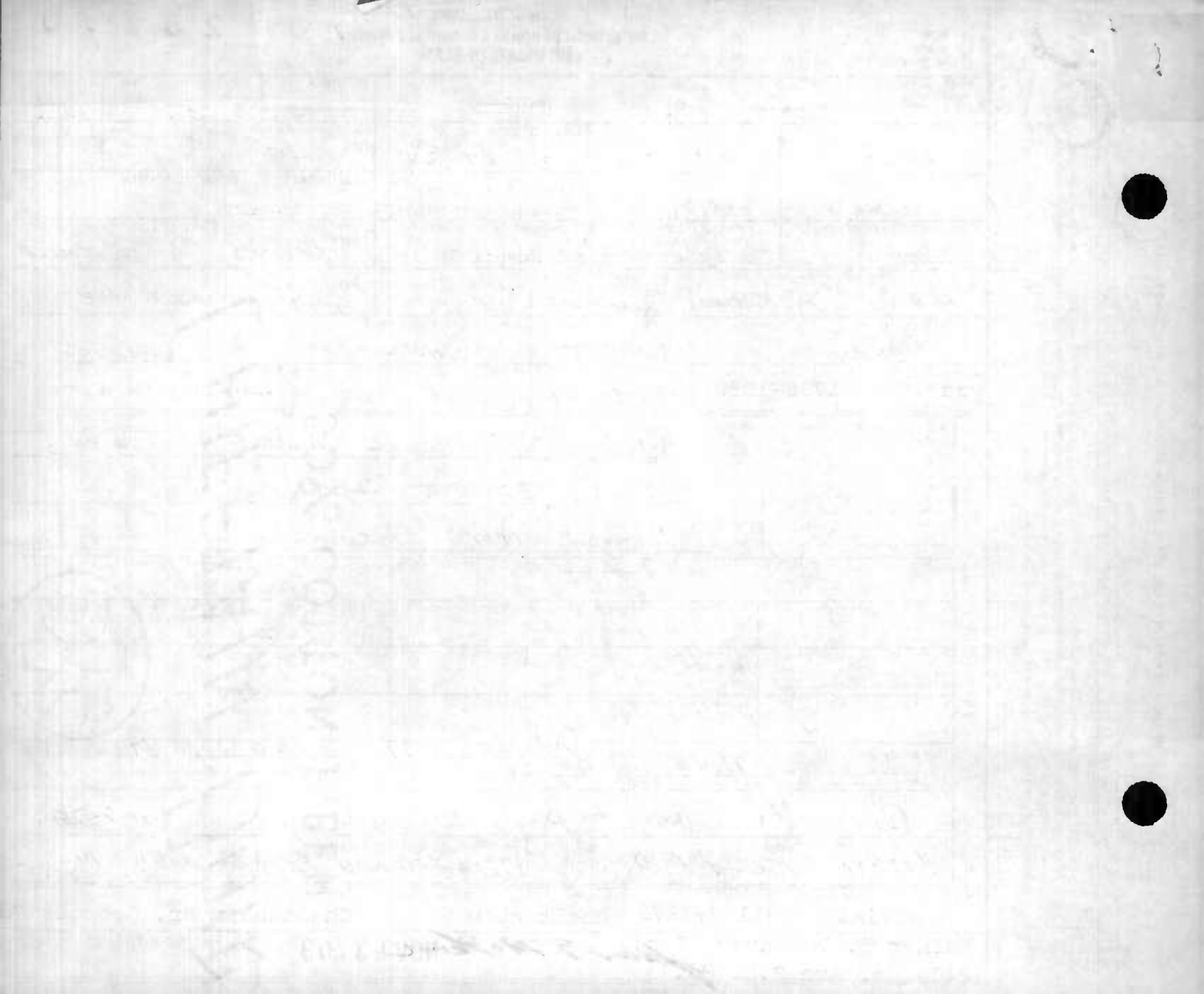
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-9-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham Pr. Georges Md</b>	
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24. FUNERAL DIRECTOR <b>Walter E. Pumphrey, Inc.</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 9 1

REG. NO.

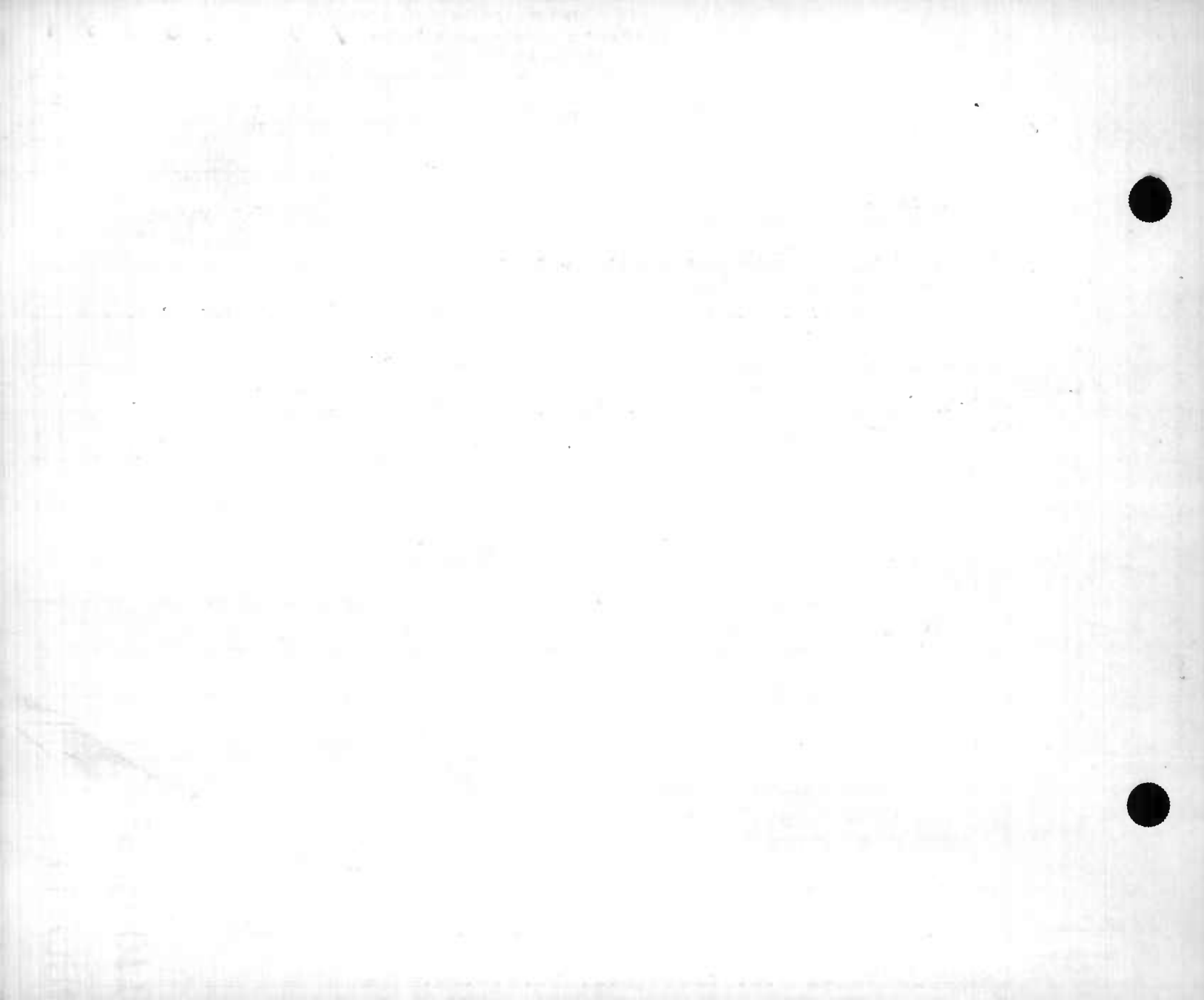
1. DECEASED NAME (TYPE OR PRINT) Rudel D. Eader			2a. DATE OF DEATH MONTH DAY YEAR 11 / 16 / 79			2b. HOUR 11:35 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 8 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Market, Md.		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATIONS (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Banker		
13a. STATE Md.					13b. COUNTY P.G.		13c. CITY OR TOWN T.P.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas H. Eader					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Baker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 09 0880		17. INFORMANT ADDRESS Christine Eader (Wife) Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4140 Congestive Cardiac Failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Respiratory Distress.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>CV. A = left hemiplegia.</u>										
19a. DATE OF OPERATION <u>11/18/79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gastrostomy, Tracheostomy</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (1) (this hospital) attended the deceased from <u>10/14/79</u> to <u>11/16/79</u> , that (1) <u>last</u> saw the deceased alive on <u>11/16/79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>viewed</u> (did not view) the body after death.										
22b. SIGNATURE <u>S. B. Goswami</u>		DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/16/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. B. GOSWAMI</u>		22e. ADDRESS <u>5401 Greystone St. Chevy Chase Md 20015</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/19/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Adelphi PG Md.</u>				
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi F.H.</u>		ADDRESS <u>11800 N.H. Ave. S.S. Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>Nov 20 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Patricia M. Brady</u>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MUSTAFA</b>		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
						<b>EBBESS</b>		<b>11 13 79</b>				<b>8:45p</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 14 1891</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>				IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LEBANON</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Market Man</b>				12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spr.</b>		<b>701 McCeney Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ebbess</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Available.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578 46 6886</b>		17. INFORMANT ADDRESS <b>Broheim Ebbess (son)</b>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pneumonia</b> <b>5335</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>pyrexia</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 days</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
**Arteriosclerosis Cardio Vascula Disease**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **2/18**, 19**77**, to **11/13**, 19**79**, that (I) (we) last saw the deceased alive on **11/13**, 19**79**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.

22b. SIGNATURE <b>Myron L. Lenkin</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Myron L. Lenkin, M.D.</b>				22e. ADDRESS <b>2309 Shorefield Rd., Wheaton, Md. 20902</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 16, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>TAKOMA FUNERAL HOME, 254 CARROLL ST.</b>							

NOV 18 1979 REGISTRAR'S OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR - STATE REGISTRAR					7 9 2 8 3 9 3														
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR									
FIRST MIDDLE LAST SHIRLEY K. EISENBERG					MONTH DAY YEAR 11-28-79					4:55 PM									
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.					
Female			White		MONTH DAY YEAR Aug. 4, 1909			70 YRS			MONTHS DAYS HOURS MIN								
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					9b. CITIZEN OF WHAT COUNTRY?					9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland					USA					Montgomery MD.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda					Fernwood Nursing Home					Attorney(Ret)					Legal				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. INSIDE CITY LIMITS?					13c. STREET ADDRESS				
13a. STATE COUNTY Florida Dade										13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13c. 5101 Collins Avenue				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Benjamin Kolker					Anna (unknown)														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					17. INFORMANT ADDRESS									
No					579-64-2503					Dr. Bonnie Eisenberg;									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 3352 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dysphagia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Myocardial Ischemic Disease</u> 14 mo 14 mo										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 14 mo 14 mo									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (the hospital) attended the deceased from <u>9-10</u> , 19 <u>79</u> , to <u>11-28</u> , 19 <u>79</u> , that (we) lost saw the deceased alive on <u>11-28-79</u> , 19 <u>79</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																			
22b. SIGNATURE W H Killay M.D., For J. Blain Fitzgerald M.D.										22c. DATE SIGNED 11-28-79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Killay J. B. Fitzgerald										22e. ADDRESS 8218 Wisconsin Ave Bethesda Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial					Nov. 30, 1979					Beth Shalom Cem.					Capitol Hts., Pr. Geo., Md.				
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Danzansky-Goldberg Chapels; 1170 Rockville Pike										Rockville, Md. DEC 3 1979					Anthony McCreedy				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 3 9 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHRISTOPHER MATTHEW EVENSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 27, 1979</b>		2b. HOUR <b>9:38P</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 7, 1959</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>20</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MASSACHUSETTS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>			MD.
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, Bethesda, Md (NIH)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COLLEGE STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>RICHARD H. EVENSEN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LORRAINE M. McNAMARA</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>025-40-7243</b>		17 INFORMANT ADDRESS <b>Mr. Richard Evensen, Father (same as above)</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2028</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
DOE TO, OR AS A CONSEQUENCE OF (b) <b>Undifferentiated Lymphoma</b>								<b>15 weeks</b>	
DOE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 14, 1979</b> , to <b>November 27, 1979</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>November 27, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE <b>Robert Maguire</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/28/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT MAGUIRE</b>				22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT. MD.</b>			
24 FUNERAL DIRECTOR <b>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

MASSACHUSETTS

COLLEGE STREET

RICHARD

EVERSON

LORRAINE

WENHAM

DEC 3 1939

200 W. BLDG. 1, SILVER SPRING, MD. 20901

FRANCIS J. COLLINS

DATE OF BIRTH

DEC 3 1939

*[Handwritten signature]*

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH KECKLEY FANSLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/6/79</b>		2b. HOUR <b>12<sup>05</sup></b> M
3. SEX <b>Female</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 15, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Mont</b>	13c. CITY OR TOWN <b>Kensington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3905 Everett St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harrison Keckley</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Forsyth</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>224 10 8128</b>		17. INFORMANT ADDRESS <b>Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphocytic Leukemia, acute</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lymphocytic Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2001</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b> <b>18 mo</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>16</b>					
19a. DATE OF OPERATION <b>2/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/78</b> , 19____, to <b>11/4/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/2/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jeremy Cooke</b> DEGREE				22c. DATE SIGNED <b>11/4/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeremy Cooke</b>				22e. ADDRESS <b>10400 Conn Ave, Kensington MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory Brentwood PG Md.</b>	
24. FUNERAL DIRECTOR NAME <b>HINES/RINALDI, F.H.</b> ADDRESS <b>11800 NEW HAMPSHIRE AVE SS, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 08 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Loring McCreedy</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CONTRACT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH	
FIRST MIDDLE LAST Alicia Fassoli		MONTH DAY YEAR November 18, 1979	
3 SEX Female		2b HOUR P 2:30 M	
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR December 2, 1924	
6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peru	
7b CITIZEN OF WHAT COUNTRY? Peru		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10 CITY OR TOWN OF DEATH Bethesda	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b KIND OF BUSINESS OR INDUSTRY Home		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b STREET ADDRESS 5816 Durbin Rd. 20034		13c CITY OR TOWN Bethesda	
14 FATHER'S NAME FIRST MIDDLE LAST Julio Manrique		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Hernandez	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. None	
17 INFORMANT Mr. Juan Fassoli, husband		ADDRESS (same as above)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metabolic disorder of electrolytes DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Lymphoma DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from October 30, 1979, to November 18, 1979, that (we) last saw the deceased alive on November 18, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) did (did not) view the body after death.			
22b. SIGNATURE Joanne K. Tobacman M.D.		22c. DATE SIGNED 11-19-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joanne K. Tobacman		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/24/79	
23c. NAME OF CEMETERY OR CREMATORY Cemetery Surquillo		23d. LOCATION CITY OR TOWN COUNTY STATE Lima, Peru	
24. FUNERAL DIRECTOR Agustin Merino F.H., Domingo Cueto 305 Lima, Peru		25a. DATE REC'D. BY REGISTRAR NOV 23 1979	
25b. REGISTRAR'S SIGNATURE			





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>George W. FEY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 11, 1979</b>		2b. HOUR <b>6:15a M</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 23, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired from United Aircraft</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Worchester</b>	13c. CITY OR TOWN <b>Ocean City</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Rey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Randels</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>511-26-9386</b>		17. INFORMANT <b>Mary Jane Fey, P.O. Box 783 Ocean City, Md.</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 17, 1979</b> to <b>Nov 11, 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov 11, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Jeffrey M. Crane</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Nov. 11, 1979</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey M. Crane</b>		22e. ADDRESS <b>NMC Bethesda, Md. 20014</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/13/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, VA</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Homes, P.A.</b> <b>7557 Wisconsin Ave., Bethesda, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Henry M. Brady</i>

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 3 9 8	
FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST <u>IRENE</u> MIDDLE <u>M.</u> LAST <u>FIELDING</u>		7a. DATE OF DEATH MONTH <u>11</u> DAY <u>9</u> YEAR <u>79</u>				7b. HOUR <u>6:15</u> AM			
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>5</u> DAY <u>6</u> YEAR <u>1893</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u>		8. UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>PENN.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.					
10. CITY OR TOWN OF DEATH <u>Gaithersburg</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Herman Wilson Health Care Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Md.</u>		13b. COUNTY <u>Mont.</u>		13c. CITY OR TOWN <u>Gaithersburg</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>301 Russell Ave.</u>			
14. FATHER'S NAME FIRST <u>Joseph</u> MIDDLE <u>Kreps</u> LAST <u>Heddings</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>Bertha</u> LAST <u>Kling</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>578-44-2624-B</u>		17. INFORMANT <u>ORpha M Des Marias Washington, DC</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Heart Disease &amp; Congestive Heart Failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/8/79</u> to <u>11/9/79</u> , that (I) (we) lost saw the deceased alive on <u>11/8/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Henry C. Scruggs</u>				DEGREE				22c. DATE SIGNED <u>11/9/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HENRY C. SCRUGGS M.D.</u>				22e. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/12/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash., D.C. 20016</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 13 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>					



NOV 13 1973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) <b>ELBIE F FISHER</b>					2a. DATE OF DEATH MONTH <b>NOV</b> DAY <b>16</b> YEAR <b>1979</b>					2b. HOUR <b>7:45</b> PM
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH <b>FEB.</b> DAY <b>26</b> YEAR <b>1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10500 Rockville Pike</b>		
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>R.</b> LAST <b>Frisbie</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Smithson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-46-4557</b>		17. INFORMANT <b>Hugh A.M. Shaffer</b> <b>6804 Crutchfield St., Falls Church, VA.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>arteriosclerotic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>14 days</b> <b>20 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Urinary tract infection</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 1</b> 19 <b>68</b> to <b>NOV 16</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>NOV 16</b> 19 <b>79</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas E O'Connor MD</b>					DEGREE			22c. DATE SIGNED <b>NOV 16, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS E O'CONNOR MD</b>					22e. ADDRESS <b>8218 WISCONSIN AVE BETHESDA MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-20-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Homes, P.A., Bethesda, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

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1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

2017年 4月



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Madeline R. Flynn			2a. DATE OF DEATH MONTH DAY YEAR November 30, 1979		2b. HOUR P 1:55 M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 27, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS MONTHS DAYS		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6802 Greyswood Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6802 Greyswood Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Reap				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Walker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 170-10-4158		17. INFORMANT ADDRESS A Elizabeth Kropp Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CACHEXIA AND INANITION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF BLADDER</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>2 YEARS</u> <u>5 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 7, 1978</u> to <u>Nov. 30, 1979</u> , that (I) (we) last saw the deceased alive on <u>Oct. 20, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph D. Connor</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>Nov. 30, 1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph D. Connor, M.D.				22e. ADDRESS 9420 Old Georgetown Rd. Bethesda, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 5, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Catherine Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Moscow Pa.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE <u>Barry McCreedy</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

NOVEMBER 20, 1978

82

CHICAGO - NOV. 17, 1978

USA

MONROVIA

HOME

MONROVIA

0801 STEVENSON RD.

WILSON

WILSON

PORT

ANCONA

170-10-1155 - ELIZABETH T. TAYLOR

NO

ELIZABETH T. TAYLOR  
170-10-1155 - ELIZABETH T. TAYLOR  
170-10-1155 - ELIZABETH T. TAYLOR

NOV 20 1978

170-10-1155

170-10-1155 - ELIZABETH T. TAYLOR  
170-10-1155 - ELIZABETH T. TAYLOR  
170-10-1155 - ELIZABETH T. TAYLOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

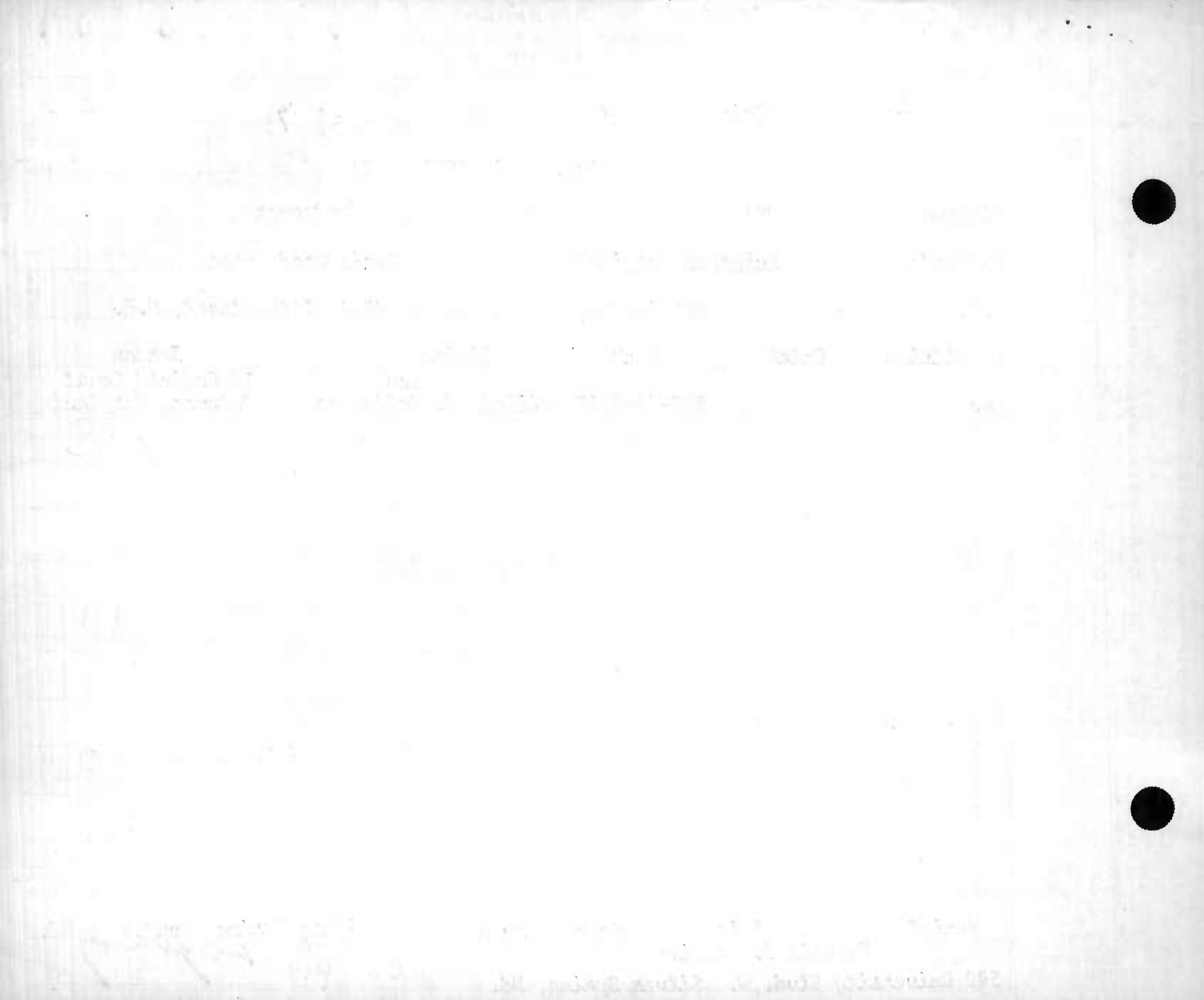
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lorraine claira Gallagher</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/29/79</b>		2b. HOUR <b>2 P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 31 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>D.C.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Washington</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4206 13th Street, N.E.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Caleb Beck</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Claire Jordan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>577-44-9017</b>		17. INFORMANT <b>son</b> <b>William C. Gallagher</b> ADDRESS: <b>10 Cafield Court Potomac, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebrovascular accident</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 years.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>3/1/74</b> to <b>11/29/79</b> , that (1) (we) lost saw the deceased alive on <b>11/29/79</b> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Sanford N. Richman, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/30/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sanford N. Richman, M.D.</b>		22e. ADDRESS <b>10401 Old Georgetown Rd. Bethesda, Md. 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
500 University Blvd., W. Silver Spring, Md.					

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 0 2

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Cheryl Lynn Gardner		MONTH DAY YEAR November 28, 1979	
2b. HOUR 4:00 P			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)
Female	White	MONTH DAY YEAR 09 17 1968	11 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
WASHINGTON, D.C.	USA		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	STUDENT	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?
Maryland	PRI. GEORGES	Mitchellville	NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST CARL GEORGE GARDNER		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH BURNS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
NO		NONE	
17 INFORMANT		ADDRESS	
Carl Gardner, father		Same	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure, second</u> <u>hemorrhage,</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute tubular necrosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10 September 79</u> to <u>28 November 79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>28 November 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.			
22b SIGNATURE Katherine Seibert MD		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) KATHERINE SEIBERT M.D.		22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
BURIAL	12/1/79	GEORGE WASHINGTON	HYATTSVILLE 20205 MD.
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR	
FRANCIS J. COLLINS		DEC 3 1979	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25b REGISTRAR'S SIGNATURE Ruthy McCreedy	

MEDICAL CERTIFICATION

BP

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Release for doctors' signature Per Dr. Richard L. Whelton Med. Exam.

# MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 2 8 4 0 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
John Joseph Gatti					November 4 1979 6 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		Feb 28 1902		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		7814 Garland Avenue				Sheet Metal Worker		Constr. Ind	
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
Maryland					Montgomery		Takoma Park		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Joseph Gatti					Carmella Conenza				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
Yes			Non-Vet		190 12 7632			Katherine L Greaner Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Emphysema</u>									20 years
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cigarette Smoking</u>									60 years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , 19 <u>76</u> , to <u>10/17</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>10/17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>Joseph B. Mizgerd, M.D.</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			11/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Joseph B. Mizgerd					7600 Carroll Ave. Takoma Park, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			11-8-1979		Cedar Hill Cemetery		Suitland Maryland		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert E Wilhelm Funeral Home Suitland Maryland					NOV 09 1979		<u>Robert E Wilhelm</u>		



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 0 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Joseph L. Geeraert</b>			2a DATE OF DEATH MONTH DAY YEAR <b>NOV. 23 1979</b>			2b HOUR <b>935 AM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>NOV. 11, 1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7a BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BELGIUM</b>		7c CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUILDER</b>		10 KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	
11 CITY OR TOWN OF DEATH <b>Bethesda</b>		12 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS <b>6401 Bradley Blvd.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>LEON - GEERAERT</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGUERITE - VANDEN ABEELE</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO <b>054-09-2467</b>		17 INFORMANT ADDRESS <b>MARCELLA GEERAERT, SAME AS #13.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1519 INANITION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>GASTRIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 1/2 year</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>JAN 19 79</b> to <b>11/23 19 79</b> , that (I) (we) lost saw the deceased alive on <b>11/23 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE <b>Daniel Rosenblum</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11/23/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL ROSENBLUM</b>			22e ADDRESS <b>10400 CONNORCUT AV KENSINGTON, MD 20795</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>NOV. 26, 1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>ST. GABRIEL'S CEM</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>POTOMAC MD</b>		
24 FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS, INC.</b>			24b ADDRESS <b>5130 WIS. AVE. N.W., WASHINGTON, D.C. 20016</b>			25a DATE RECD. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	





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Mr. J. H. ...

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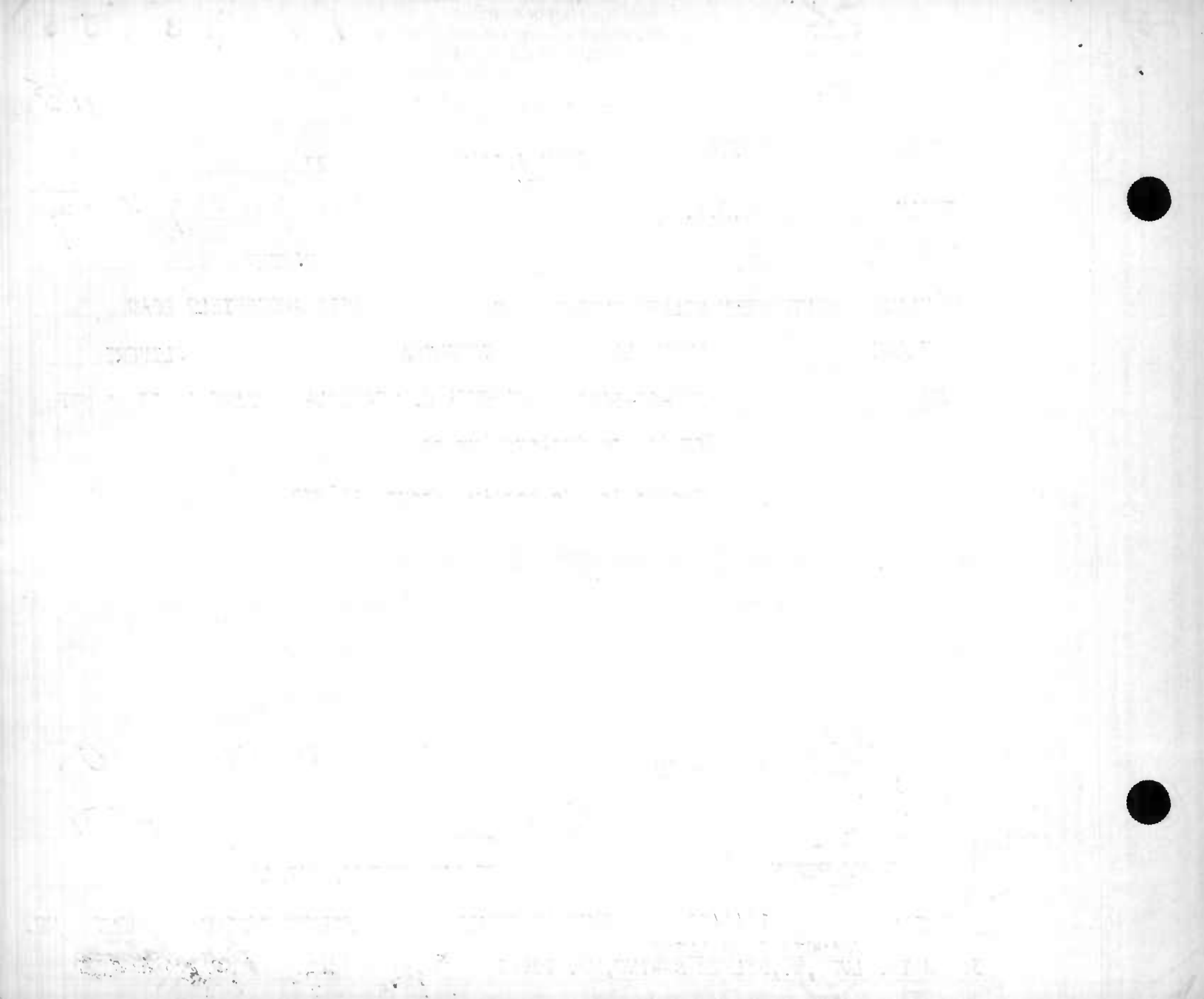
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 4 0 5			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JASPER</b>			FIRST <b>GIANNOLA</b>			LAST	
2a. DATE OF DEATH			MONTH <b>11</b> DAY <b>5</b> YEAR <b>79</b>			2b. HOUR <b>11</b> <sup>05</sup> <sub>PM</sub>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		5 DATE OF BIRTH MONTH <b>JULY</b> DAY <b>4</b> YEAR <b>1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BARBER</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>SILVER SPRING</b>	
14. FATHER'S NAME FIRST <b>FRANK</b> MIDDLE <b>GIANNOLA</b> LAST <b>JOVENINA</b>			15. MOTHER'S MAIDEN NAME FIRST <b>JOVENINA</b> MIDDLE <b>OLIVERI</b> LAST <b>OLIVERI</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>578-22-3003</b>			17. INFORMANT ADDRESS <b>NINETTA C. GIANNOLA SAME AS 13 WIFE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Cardio Respiratory Arrest</b> IMMEDIATE CAUSE (a) <b>486-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia, Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>486-</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-5-79</b> to <b>11-5-79</b> , that (I) (we) last saw the deceased alive on <b>11-5-79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Morris Perry</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-5-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRIS PERRY</b>				22e. ADDRESS <b>SILVER SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>	
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 28406			
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Gillice</b>						2a. DATE KNOWN OF DEATH EST. MATED <b>Nov 18 1979</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 20 31 48</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>31 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov 19 1979</b>		2d. HOUR <b>1:30 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Sil. Spg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1110 Fiddle Lane Apt. 910</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Insurance Sales Insurance</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>	13c. CITY OR TOWN <b>Sil. Spg</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS <b>1110 Fiddle Lane Apt 910</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas W. Gillice</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Zereta Mae Collins</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>					
16b. SOCIAL SECURITY NO. <b>321-26-1103</b>		17. INFORMATION <b>Ex-wife 309 Maple Ave., Sondra J. Gillice-Falls Ch. Va.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>954- Drowning in 132th tub.</b> IMMEDIATE CAUSE (a) <b>Drowning in 132th tub.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Overdose Drugs and Alcohol</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11-18-79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Drowning in bathtub after overdose</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Fiddle Lane, Sil. Spg, Mont, Md</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-21-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairmont Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Willow Springs Cook Ill.,</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b>		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>					



Chadman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 28407			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>John D. Glasheen</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 30 79</b>		2b. HOUR <b>1158</b> M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 18 14</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Personnel Dir.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Bethesda</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5225 Pooks Hill Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John A. Glasheen</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence - Lansing</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>-</b>		17 INFORMANT ADDRESS <b>Frances T. Glasheen-Address same as #13.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac fibrillation &amp; arrest</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Probable acute myocardial infarction</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>Hypertensive arteriosclerotic cardiovascular disease</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Chronic obstructive pulmonary disease</b>							
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 30 19 79</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/30</b> , 19 <b>79</b> , to <b>11/30</b> , 19 <b>79</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>11/30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert Birschbach MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/30/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT BIRSCHBACH</b>				22e. ADDRESS <b>10401 Old Georgetown Rd. Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>Dec./3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Med'l School</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Chambers Funeral Home - Silver Spring, Md.</b>				25a. DATE REC'D BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

John D. Glasheen 11 30 75

Half White 8 18 24 62

Montgomery

Robinson

Recheads

Robert Rinschman

Chambers, James H. 11 30 75

Chambers, James H. 11 30 75



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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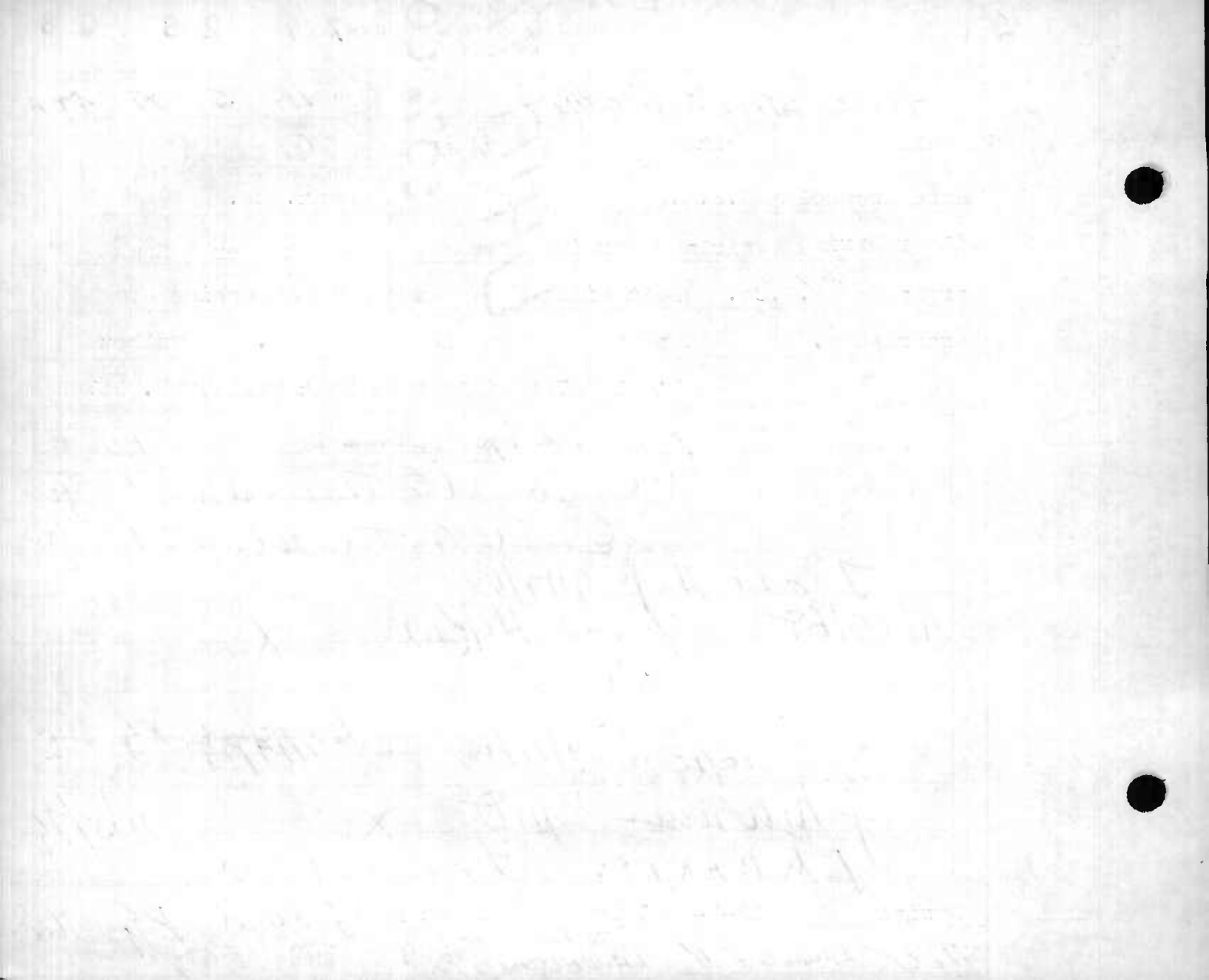
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ALICE STELLA GODFREY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11-5-79</b>			2b HOUR <b>400 A M</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 24 1888</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Anne Arundel</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Mont. Co.</b> MD			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairland Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Book keeper</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>P.G.Co.</b>		13c CITY OR TOWN <b>Beltsville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>4600 Josephine Ave</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Zarhariah T. Chaney</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie A. Talbot</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					
16b SOCIAL SECURITY NO. <b>218 20 0763</b>		17 INFORMANT ADDRESS <b>4600 Josephine Ave Billy Rolf Beltsville, Md. 20705</b>							
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4370</b> <b>bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> 15 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Fract Hip 9/17/68</b>									
19a DATE OF OPERATION <b>9/19/68</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fract. Hip (R)</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/17 1968</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Laurel Rd</b>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f LOCATION CITY OR TOWN COUNTY STATE <b>Laurel PG md</b>					
22a I certify that (I) (this hospital) attended the deceased from <b>4/17/68</b> 19 <b>79</b> to <b>11/4/79</b> 19 <b>79</b> that (I) [we] last saw the deceased alive on <b>10/30</b> 19 <b>79</b> and that in [my] [our] opinion death occurred on the date and hour and from the causes stated above. (I) [we] did (did not) view the body after death.									
22b SIGNATURE <b>J M Warren</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>11/5/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>J M WARREN</b>		22e ADDRESS <b>Laurel Md</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>11-7- 1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Laurel PG md</b>			
24 FUNERAL DIRECTOR NAME <b>FLECK LAUREL F H</b>		ADDRESS <b>7601 Sandy Sp</b>		25a DATE RECD. BY REGISTRAR <b>NOV 7 1979</b>		25b REGISTRAR'S SIGNATURE <b>Fitzroy H. H. H.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

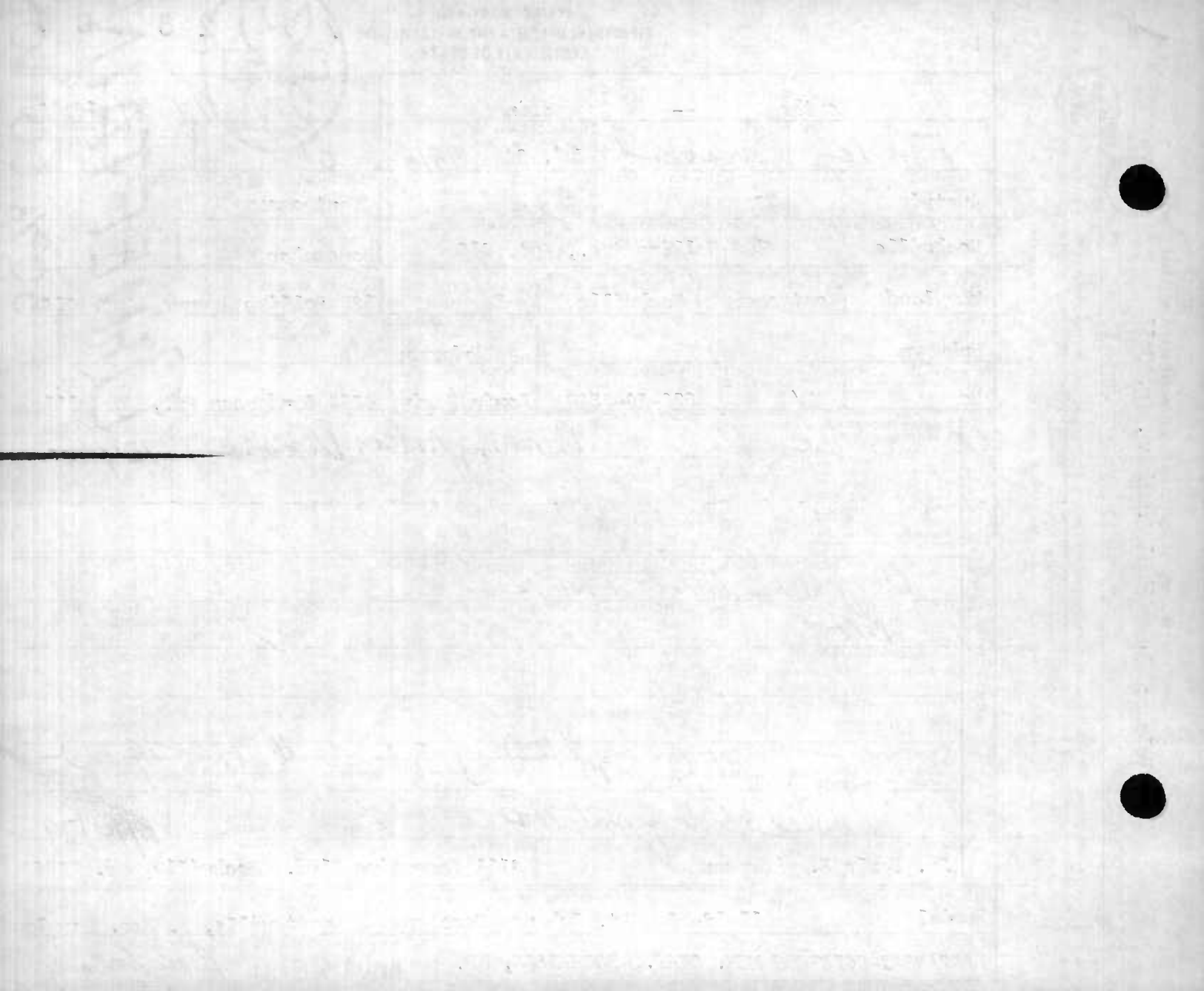
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

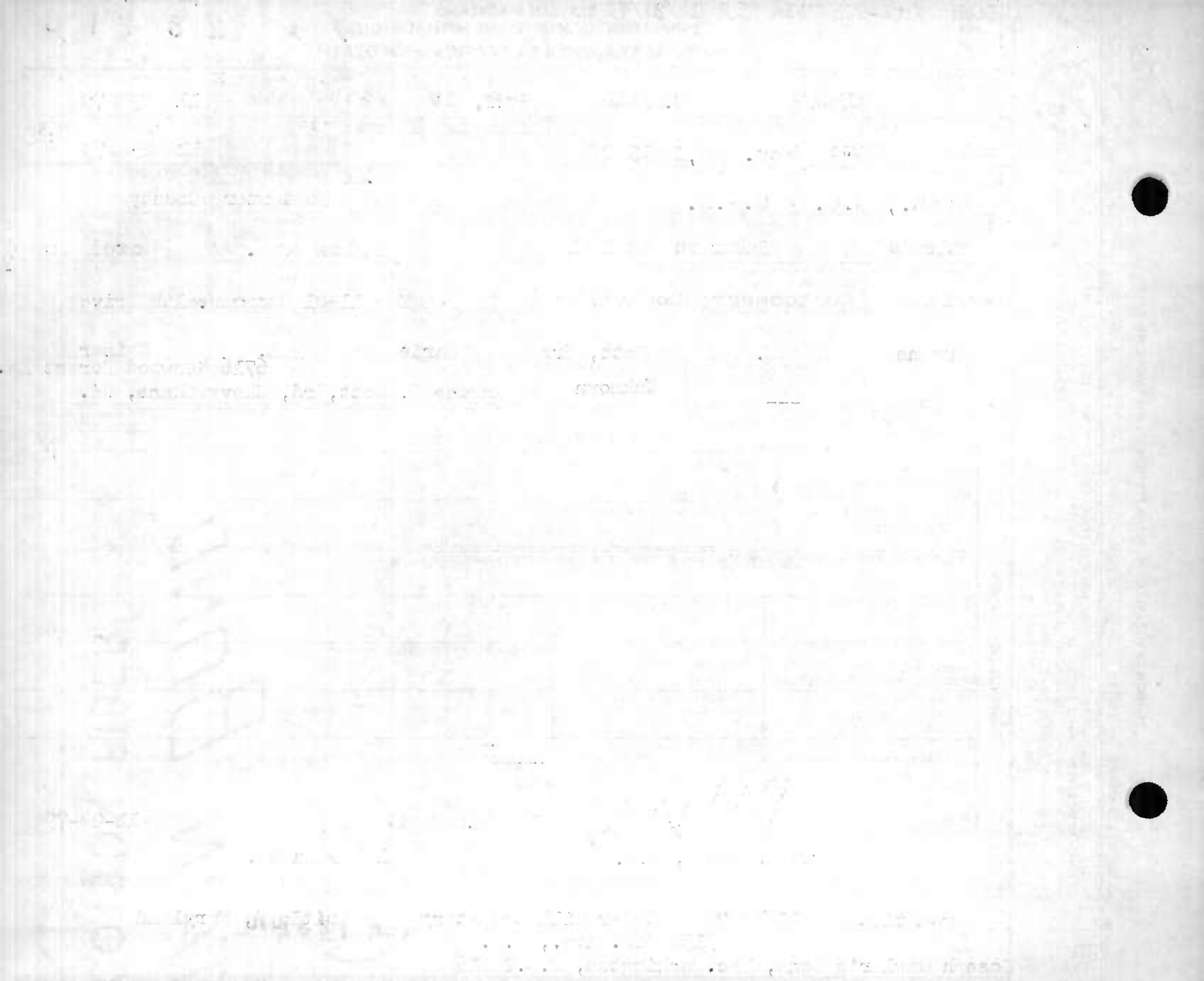
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 7 9 2 8 4 0 9									
1. FOR STATE REGISTRAR					2a. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha --- Gorin					MONTH DAY YEAR 11 14 79				
2b. HOUR 10:15am									
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jul. 24 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 199 Rollins Ave., Apt. 615				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13e. STREET ADDRESS 199 Rollins Avenue, Apt. 615			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Louis Gorin, 4309 Landgreen St., Maryland Rockville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (b) 13 years DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Correlative Heart Failure									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (name hospital) attended the deceased from 2/13/79 to 11/14/79, that (1) I saw the deceased alive on 8/13/79 and that in my own opinion death occurred on the date and hour and from the causes stated above. (1) (name) did not view the body after death.									
22b. SIGNATURE Earle B. Thompson MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/14/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Earle B. Thompson					22e. ADDRESS 6111 Executive Blvd., Rockville, Md. 20852				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-16-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, P. Geo. Maryland			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP., ADDRESS ROCKVILLE, MD.					25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE Ruthy McBrady		

0904



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)										20. DATE OF DEATH		21. HOUR	
FIRST			MIDDLE			LAST				KNOWN ESTIMATED	MONTH	DAY	YEAR
EUGENE CISCSEL GOTT, IV										<input checked="" type="checkbox"/>	11	23	1979
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD	
male		white		Apr. 28, 1955		24 YRS.		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH	
Wash., D.C.				U.S.A.								Montgomery County MD.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda				Suburban Hospital				Sales Rep.				Hotel Supply	
13a. STATE				13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Montgomery		Rockville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11401 Commonwealth Drive			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Eugene C. Gott, 3rd				Marie L. Kaiser									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT					
No				Unknown				Eugene C. Gott, 3rd, Chevy Chase, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Undetermined													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
								STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Ann M. Dixon, M.D.				Assistant				11-24-79					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Ann M. Dixon, M.D.				111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Cremation				11/25/79		Cedar Hill Crematory				CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE RECEIVED BY REGISTRAR					
Joseph Gawler's Sons, Inc.				5130 Wis. Ave., N.W. Washington, D.C. 20016				25b. REGISTRAR'S SIGNATURE					



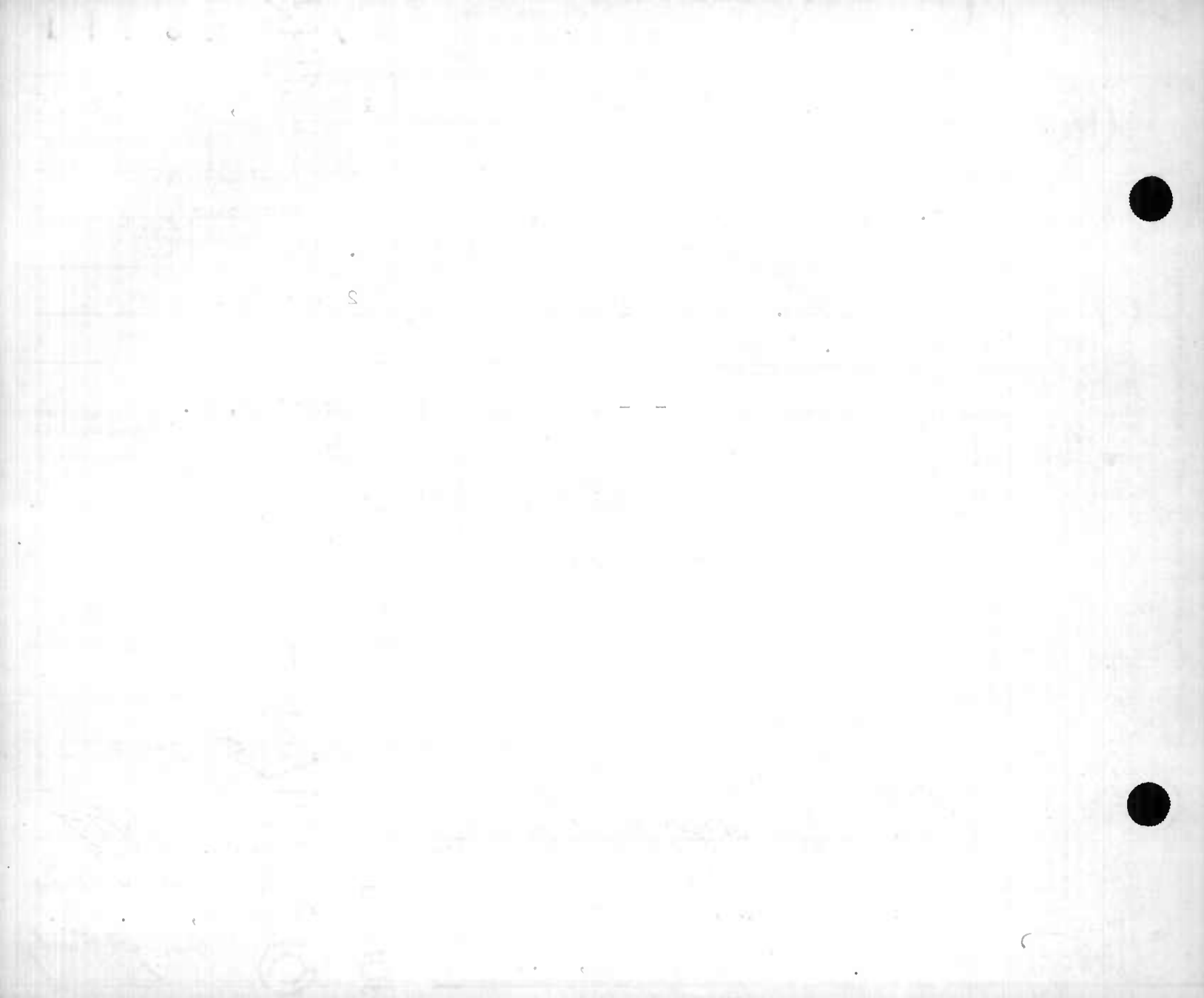
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 2 8 4 1 1		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
PEARL LEE GOVER						NOVEMBER 5, 1979		5:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		March 24, 1900		79 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA				Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital				H. Wife		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Mont.		Rockville				302 Park Road	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
James J. Day				Bessie Belle Gray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
no				213-74-0882		Bessie Whipp Rockville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic use of stamnia</u> (c) <u>myocardial infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>11/3</u> 19 <u>79</u> , to <u>11/5</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11/3</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James L. Hooper MD</u>				22c. DATE SIGNED <u>11/5/79</u>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES L. HOOPER MD</u>	
22e. ADDRESS <u>15 DEER PARK DRIVE GAITHERSBURG, MD 20878</u>				22f. ADDRESS <u>15 DEER PARK DRIVE GAITHERSBURG, MD 20878</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Nov. 8, 1979		Forest Oak		Gaithersburg, Mont. Md.			
24. FUNERAL DIRECTOR NAME Francis H. Barber				ADDRESS Laytonsville, Md. 20760		25a. DATE REC'D. BY REGISTRAR NOV 8 1979			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 4 1 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Altah</i>		FIRST <i>ALTAH</i> MIDDLE <i>L</i> LAST <i>GRIGGS</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>11 25 79</i>		2b. HOUR <i>6 00 AM</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 11 1884</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>95</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD	
10 CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Nimrod Smith</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Elizabeth Schindler</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>577-70-3377</i>		17 INFORMANT ADDRESS <i>Md.</i>		17. E.H. Bowers, Dtr., 5907 Cromewell Dr., Beth.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Heart failure</i> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerotic Heart disease</i> (c) <i>Arteriosclerosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Kidney disease - nephrosis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9/10 79</i> to <i>11/25 79</i> , that (I) <i>yes</i> lost saw the deceased alive on <i>11/28/79</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (was I not? did not? view the body after death?)							
22b. SIGNATURE <i>Thos G. Ward</i> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/25/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thos G. Ward, 6116 Rockwood, Bethesda, Md 20834</i>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/27/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Md.</i>	
24 FUNERAL DIRECTOR NAME <i>Joseph Gawler's Sons Inc.</i>				ADDRESS <i>5130 Misc. Ave., N.W. Wash. D.C.</i>		25a. DATE RECEIVED BY REGISTRAR <i>NOV 28 1979</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



Signed in absence of Dr. Kenton  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death and retained by the hospital or attending physician.

DHMH-16 20M  
(VRA 15, 4) 7/78

Item #5 Film 0538 12/28/79 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 1 3

FOR  
STATE  
REGISTRAR

REG. NO.

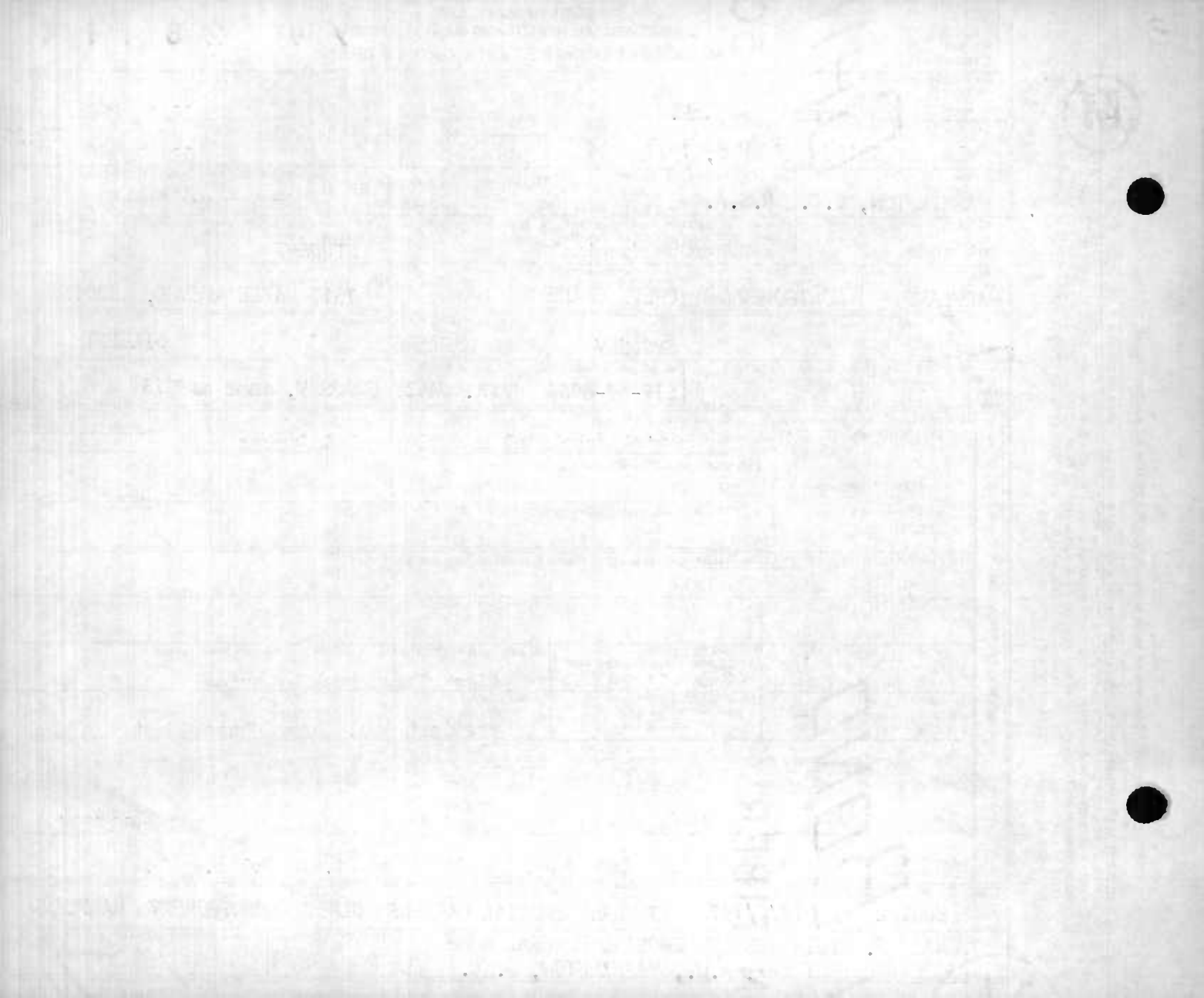
1 DECEASED NAME (TYPE OR PRINT) <b>CULENA R. GRIGSBY</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11. 24. 79</b>		2b HOUR <b>5:40 P M</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>7 23 79</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		10 CITY OR TOWN OF DEATH <b>Kensington</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens N.H.</b>		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>home</b>				
13a STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Kensington</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>James D. Thorne</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Raum</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		
16b SOCIAL SECURITY NO. <b>---</b>		17 INFORMANT <b>Mrs. Virginia Motley</b>		ADDRESS <b>3017 Ferndale St. Kensington, Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interosseclerotic heart disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b> Approximate interval between onset and death: <b>years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (this hospital) attended the deceased from <b>Sept 13, 19 79</b> , to <b>Nov 24, 19 79</b> , that (we) last saw the deceased alive on <b>Nov 24, 19 79</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (you) (did) (not) view the body after death.						
22b SIGNATURE <b>A.W. Smith M.A.</b>		DEGREE		22c DATE SIGNED <b>11/24/79</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.W. SMITH</b>		22e ADDRESS <b>13018 GEORGIA AVE WHEATON, MD. 20906</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Nov. 27, 1979</b>		23c NAME OF CEMETERY OR CREMATORIUM <b>Providence Metho. Friendly,</b>		
24 FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey</b>		ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>		25a DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		
				25b REGISTRAR'S SIGNATURE <b>Hickory McBrady</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 8 4 1 4	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		7b. HOUR	
Jeremy KEVIN Grodsky						11 29 1979		11 29 1979		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		White		JULY 2, 1971		8 YRS.		MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
WASHINGTON, D.C.		U.S.A.		WIDOWED		DIVORCED		Montgomery County, MD.		10:25 P M	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hospital			STUDENT					
13a. STATE											
MARYLAND											
13b. COUNTY											
MONTGOMERY											
13c. CITY OR TOWN											
CHEVY CHASE											
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
13e. STREET ADDRESS											
7317 MAPLE AVENUE, 20015											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
DAVID GRODSKY						MARLENE GILBERT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO						219-68-6966			Dr. DAVID GRODSKY, same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Multiple skeletal and visceral injuries											
8147											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
20. AUTOPSY?						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY					
8:30 P.M. 11 29 1979						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
pedestrian struck by auto											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					
street						21f. LOCATION					
Connecticut Ave. Chevy Chase, Mont. MD.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE						TITLE (SPECIFY)					
Virginia L. Dolan M.D.						Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)						DATE SIGNED					
Virginia L. Dolan, M.D.						11/30/79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE					
BURIAL						12/2/1979					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION					
JUDEAN MEMORIAL GARDENS						OLNEY MONTGOMERY MARYLAND					
24. FUNERAL DIRECTOR											
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME											
235. DATE REC'D. BY REGISTRAR											
236. REGISTRAR'S SIGNATURE											
232 CARROLL STREET, N.W., WASHINGTON, D. C. DEC 4 1979											





BH

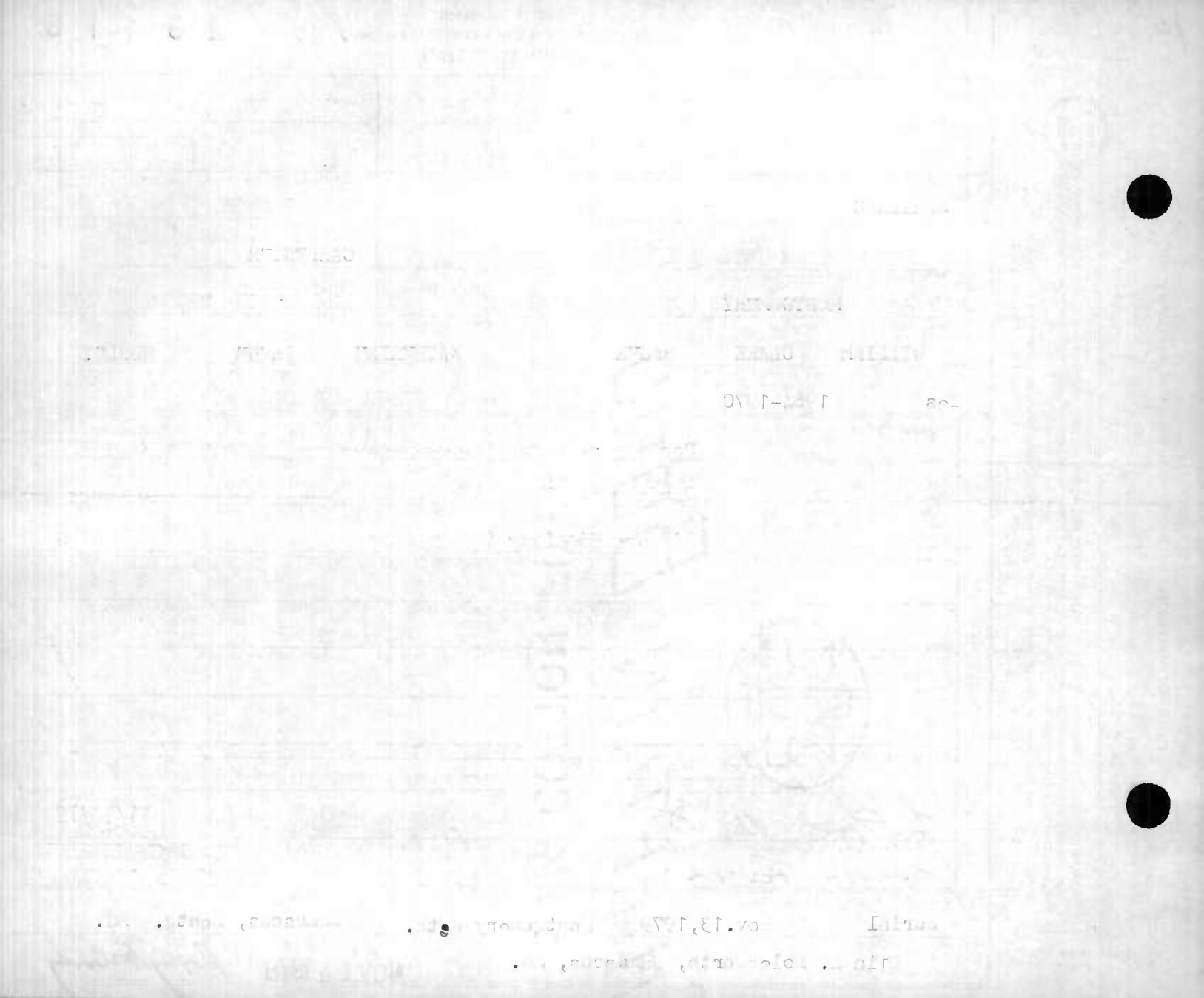
DHM - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 8 4 1 5	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
JAMES CLAUD HAGER				NOVEMBER 9, 1979	
3. SEX		4. RACE		5. DATE OF BIRTH	
MALE		WHITE		JUNE 6, 1943	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
MARYLAND		USA		36 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
BETHESDA		THE CLINICAL CENTER		MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS	
CARPENTER				124 TULIP DRIVE 20760	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
WILLIAM CLARK HAGER		KATHERINE IRENE HURLEY		Yes	
17. INFORMANT		18. CAUSE OF DEATH		19. SOCIAL SECURITY NO.	
SAME AS ABOVE		Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 2000 } DUE TO, OR AS A CONSEQUENCE OF (b) Pericordial Tamponade (c) Diffuse Histiocytic Lymphoma PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)		220-40-3512	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from OCTOBER 17, 1979, to NOVEMBER 9, 1979, that (we) lost saw the deceased alive on NOVEMBER 9, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Brenda Foster				11/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23. NAME OF CEMETERY OR CREMATORY	
Brenda Foster		NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
				Burial	
				23b. DATE	
				Nov. 13, 1979	
				23c. LOCATION	
				Montgomery Md. Damascus, Montg. Md.	
				23d. LOCATION	
				CITY OR TOWN COUNTY STATE	
				20705	
				24. FUNERAL DIRECTOR	
				NAME	
				Olin L. Molesworth, Damascus, Md.	
				25a. DATE REC'D. BY REGISTRAR	
				NOV 13 1979	
				25b. REGISTRAR'S SIGNATURE	
				[Signature]	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 1 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL FREDERICK HALL			2a. DATE OF DEATH MONTH DAY YEAR November 18, 1979		2b. HOUR P 6:00 P M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 31, 1951	6 AGE (IN YEARS LAST BIRTHDAY) 28 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U S A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md (NIH)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY I R S	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia			13b. COUNTY Fairfax	13c. CITY OR TOWN Lorton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Samuel E. Hall			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marie Hischmiller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 406-74-0338		17 INFORMANT ADDRESS Mrs. Anna Hall, 1337 Greenup St Covington, Ky	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 7469 DUE TO, OR AS A CONSEQUENCE OF (b) Status post repair of double outlet right ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Congenital Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 days 28 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Failure					
19a. DATE OF OPERATION November 18, 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right and Left Heart Failure		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from November 4, 1979, to November 18, 1979, that I (we) last saw the deceased alive on November 18, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.					
22b. SIGNATURE F. Von Rueben M.D.				22c. DATE SIGNED 11/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. Von Rueben M.D.				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/23/79	23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Mitchell-Kenton Co. Ky.
24 FUNERAL DIRECTOR NAME W. W. Chambers Co., Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR NOV 23 1979 25b. REGISTRAR'S SIGNATURE Hofrey McCready	

55  
26  
23  
738  
3

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18 G53 8 12/18/79 dad				STATE OF MARYLAND			
1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Ernest Roy Haller, JR				11-2-79			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		white		MONTH DAY YEAR		59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
WASH D.C.		USA				MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK		Washington Adventist Hosp.		Retired		BANKING	
13a. STATE				13b. CITY OR TOWN			
MD				Hillside			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
ERNEST ROY HALLER SR.				EDNA HAYDEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				17. INFORMANT			
NO				E. ROY HALLER SR. SAME AS ITEM 13			
18. CAUSE OF DEATH Enter: only one cause per line for (a), (b), and (c). IMMEDIATE CAUSE (a) <u>respiratory failure</u> (b) <u>myocardial infarction</u> (c) <u>stroke</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> 19 <u>79</u> , to <u>11/2</u> 19 <u>79</u> , that (I) (we) lost above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE				22c. ADDRESS		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS		22g. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		11-5-79		CEDAR Hill CEM.		SWITLAND MD.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
G.P. KALAS 6160 OXON HILL RD. OXON HILL, MD.				NOV 05 1979			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CONSTANCE JOY HARRINGTON					2a. DATE OF DEATH MONTH DAY YEAR November 1, 1979			2b. HOUR 2:35 pm		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR August 26, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Prince Geo		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/> YES <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Francis Redden					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Perle Victoria					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 477-30-1774		17 INFORMANT John Harrington			ADDRESS same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 1749 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Meninjeal Carcinomatosis</u> 26 Months (c) <u>Breast Carcinoma</u> 17 Months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 2, 1979</u> to <u>November 1, 1979</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>November 1, 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE <u>Alan J. Fabell</u>						22c. DATE SIGNED Nov. 1, 1979		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN J. LABELL				22f. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-5--79		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Geo. Md.				
24 FUNERAL DIRECTOR NAME Robert G. Beall Funeral Home 9013 Annapolis Rd. Lanham, Md.				25a. DATE REC'D. BY REGISTRAR NOV 5 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BP



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1771-1772

1771-1772

1771-1772

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William S. Hepner SR.			2a. DATE OF DEATH MONTH DAY YEAR 11 23 79			2b. HOUR 5:30 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12/ 11/ 88		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ass't. Adm.		12b. KIND OF BUSINESS OR INDUSTRY Amer. Red Cross	
13a. STATE Md.			13b. CITY OR TOWN Montg.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4914 Montgomery Lane		
14. FATHER'S NAME FIRST MIDDLE LAST Orville Hepner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva (Unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT 6704 Heatherford Ct. William S. Hepner, Jr. Derwood, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4440 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>16 years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Uncluttered</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 20</u> , 19 <u>79</u> , to <u>Nov. 23</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov. 22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>John D. Herman</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/23/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Herman			22e. ADDRESS 4425 Montgomery Ln. Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Nov. 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.		
24. FUNERAL DIRECTOR NAME Homes, P.A.			24b. ADDRESS Bethesda, Md.			25a. DATE RECD. BY REGISTRAR NOV 29 1979			



22

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WHITE

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275-46-2251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LUCY E HESS</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>2</b> YEAR <b>1979</b>			2b. HOUR <b>8:20 P.M.</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>23</b> YEAR <b>14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Canada</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION, LAST OF WORK FOR MOST OF WORKING LIFE <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>PRINCE GEORGE</b> 13c. CITY OR TOWN <b>TAKOMA PARK</b>		14. FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b>J.</b> LAST <b>Butler</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Louisa</b> MIDDLE <b>G.</b> LAST <b>Garrett</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6706 CONWAY AVE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>068-05-8502</b>		17. INFORMANT <b>Walter Hess</b>		ADDRESS <b>(13e)</b>					

18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Ventricular Fibrillation**

4254  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Coronary atherosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**Instantaneous**

**15 years**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>January 1974</b> , to <b>Nov 2</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Blaine H. Eig</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Nov 3, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BLAINE H. EIG</b>		22e. ADDRESS <b>9801 George Ave Silver Spring, Md 20902</b>					

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>Nov. 8-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR (TYPE OR PRINT) <b>Walter Hess</b>		ADDRESS <b>354 Carroll St. NE</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Heston McBrady</b>	

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DHMH-16-20M  
(VRA 15, 4) 7/78

14

AMERICAN

1927

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 2 8 4 2 1						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Estelle M. Hill</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11-16-79</b>		2b. HOUR <b>10<sup>PM</sup></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 25, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Admin.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince Geo. Bowie</b>		13c. CITY OR TOWN <b>Westmont Lane</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. Morrison</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Rivest</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>016-10-0254</b>			17. INFORMANT ADDRESS <b>3913 Winchester Ln. Kathryn L. Marble-Bowie, Md. 20715</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1749 METASTATIC CARCINOMA OF (2) BREAST</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF (2) BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>EPIDURAL SPINAL CORD COMPRESSION</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>NOVEMBER 1, 1979</b> to <b>NOVEMBER 16, 1979</b> , that (we) lost saw the deceased alive on <b>NOVEMBER 16, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>James A. Brown MD</b>				DEGREE				22c. DATE SIGNED <b>11/17/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. BROWN MD</b>				22e. ADDRESS <b>6525 BELMONT RD HYATTSVILLE MD 20782</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Rose Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sp. Hadley-Hampshire-Mass.</b>			
24. FUNERAL DIRECTOR NAME <b>Nalley's Funeral Home-Mt. Rainier, Md.</b>				24a. DATE RECEIVED BY FUNERAL DIRECTOR <b>NOV 20 1979</b>		24b. SIGNATURE OF FUNERAL DIRECTOR <b>[Signature]</b>			

0403

Halifax 5 Nov 45 - P. H. H. H. H.

London 5 Nov 45 - P. H. H. H. H.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 2 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ralph S. Hisle Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 18 1979</b>			2b. HOUR <b>6:16P<sub>M</sub></b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 10 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Appraiser</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Bethesda</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>5517 Brite Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph S. Hisle, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Beach</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-28-8075</b>		17. INFORMANT ADDRESS <b>Mary N. Hisle (Same as 13e)</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTEROSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>OLD MYOCARDIAL SCARRING - HEPATOMEGALY</b>					
19a. DATE OF OPERATION <b>0</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>0</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 10 1976</b> to <b>JUNE 4 1979</b> , that (I) (we) last saw the deceased alive on <b>JUNE 11 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert L Flynn MD</b>		DEGREE		22c. DATE SIGNED <b>11/19/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert Flynn</b>		22e. ADDRESS <b>5454 Wisconsin Ave. Chevy Chase, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-21-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>	
				25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	

MEDICAL CERTIFICATION

5903 BP



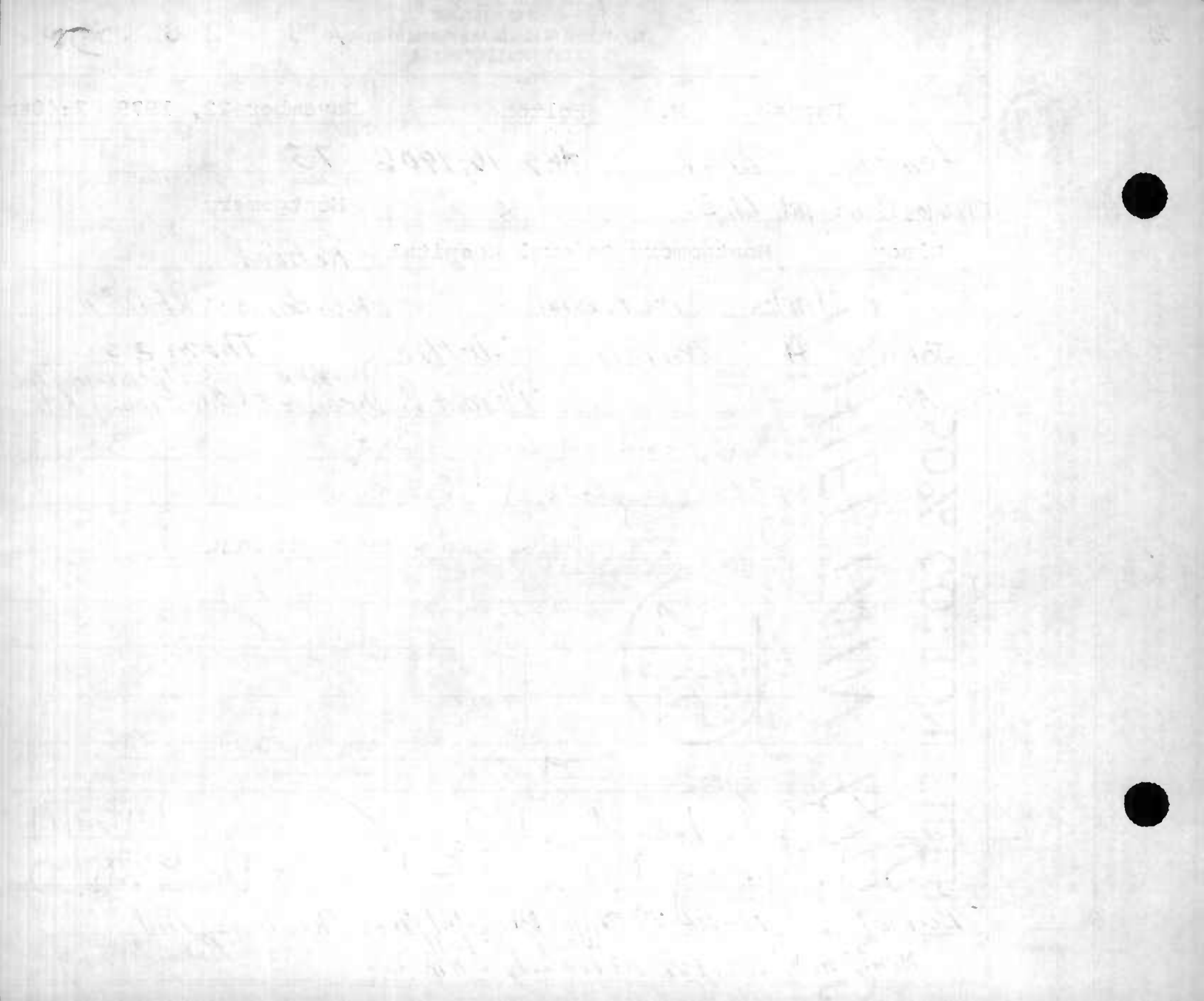
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO. 7 9 2 8 4 2 3					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hannah M. Holton					2a DATE OF DEATH MONTH DAY YEAR November 22, 1979			2b HOUR 2:40am		
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Charles County, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD					13b COUNTY Newburg Md.		13c CITY OR TOWN P.O. Box 55 RFD #1		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John H. Carroll					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dottie Thomas					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b SOCIAL SECURITY NO.		17 INFORMANT Daughter Pleasant V. Dyson - 8821-Emory Rd. Gaithersburg Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:										
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 11/22/79 to 11/22/79, that (I) (we) last saw the deceased alive on 11/22/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state date and hour of death.)										
22b SIGNATURE S. Dolinsky MD					DEGREE MD			22c DATE SIGNED 11/22/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS 15 E Deer Pk Dr Gaithersburg Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b DATE 11-26-79			23c NAME OF CEMETERY OR CREMATORY Shiloh Methodist Church		
24 FUNERAL DIRECTOR NAME Montgomery Bros. Inc.					24b ADDRESS Wash DC 20011			24c DATE REC'D BY REGISTRAR DEC 3 1979		
25a NAME OF REGISTRAR H. H. H. H.					25b ADDRESS 114 KENNY ST NW					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 2 4	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert A. Hughes</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 19, 1979</b>			2b. HOUR <b>12:25PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 20 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Employee Clerk of Court</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rockville, Md.</b>			
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Laytonsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>(un known)</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(unknown)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>WWII 214-28-3943</b>		17. INFORMATION (Atty) <b>22 W. Jefferson St. Milton Clogg -Rockville, Md. 20850</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intra-Cranial Hemorrhage</b> <b>4329</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Unclot.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>10-25</b> , 19 <b>79</b> , to <b>11-19</b> , 19 <b>79</b> , that (I) <del>last</del> saw the deceased alive on <b>11-19-79</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) <del>did</del> did not view the body after death.											
22b. SIGNATURE <b>Jack Schumacher M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-20-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack Schumacher, MD</b>						22e. ADDRESS <b>105 Russell Ave., Gaithersburg, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-23-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sil. Spr. Montgomery Md.</b>				
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Kathy K. Brady</b>			
8434 Ga. Ave., S.S. Md.											

MEDICAL CERTIFICATION

29

0100 BP

15. 11. 1954





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be reported to the health department within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 2 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Louise Dorothy Humphries</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>November 11, 1979</b>	
3. SEX <b>Female</b>		2b. HOUR <b>7:40</b> P M	
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 20, 1912</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Hampshire</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH, CLINICAL CENTER</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired - Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>FLORIDA</b>		13b. COUNTY <b>DONNELSON</b>	
13c. CITY OR TOWN <b>DONNELSON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>416 DAVIS AVE</b>		32630	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernice Ingerson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Guynn</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b> (IF YES, GIVE WAR OR DATES) <b>None</b>		16b. SOCIAL SECURITY NO. <b>007-32-8109</b>	
17. INFORMANT ADDRESS <b>Mr. Kenneth Humphries, (husband)</b>		(same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Breast Cancer Metastatic</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (d) <b>Breast Cancer Metastatic</b> (e) <b>DUE TO, OR AS A CONSEQUENCE OF</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) this hospital attended the deceased from <b>October 29, 1979</b> to <b>November 11, 1979</b> , that I (we) lost saw the deceased alive on <b>November 11, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) we (did) (do not) view the body after death.			
22b. SIGNATURE <b>Gerald B. Ahmann</b>		22c. DATE SIGNED <b>11-12-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gerald B. Ahmann</b>		22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md 20205</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-12-79</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C. 20002</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Pietro K. Brady</b>			



New Hampshire

US

retired - w se

Jack Quinn

Bernice Ingram

ere

Creation

11-15-72

Jack's Creation

Washington, D.C. 20008

Jack's Creation 11-15-72

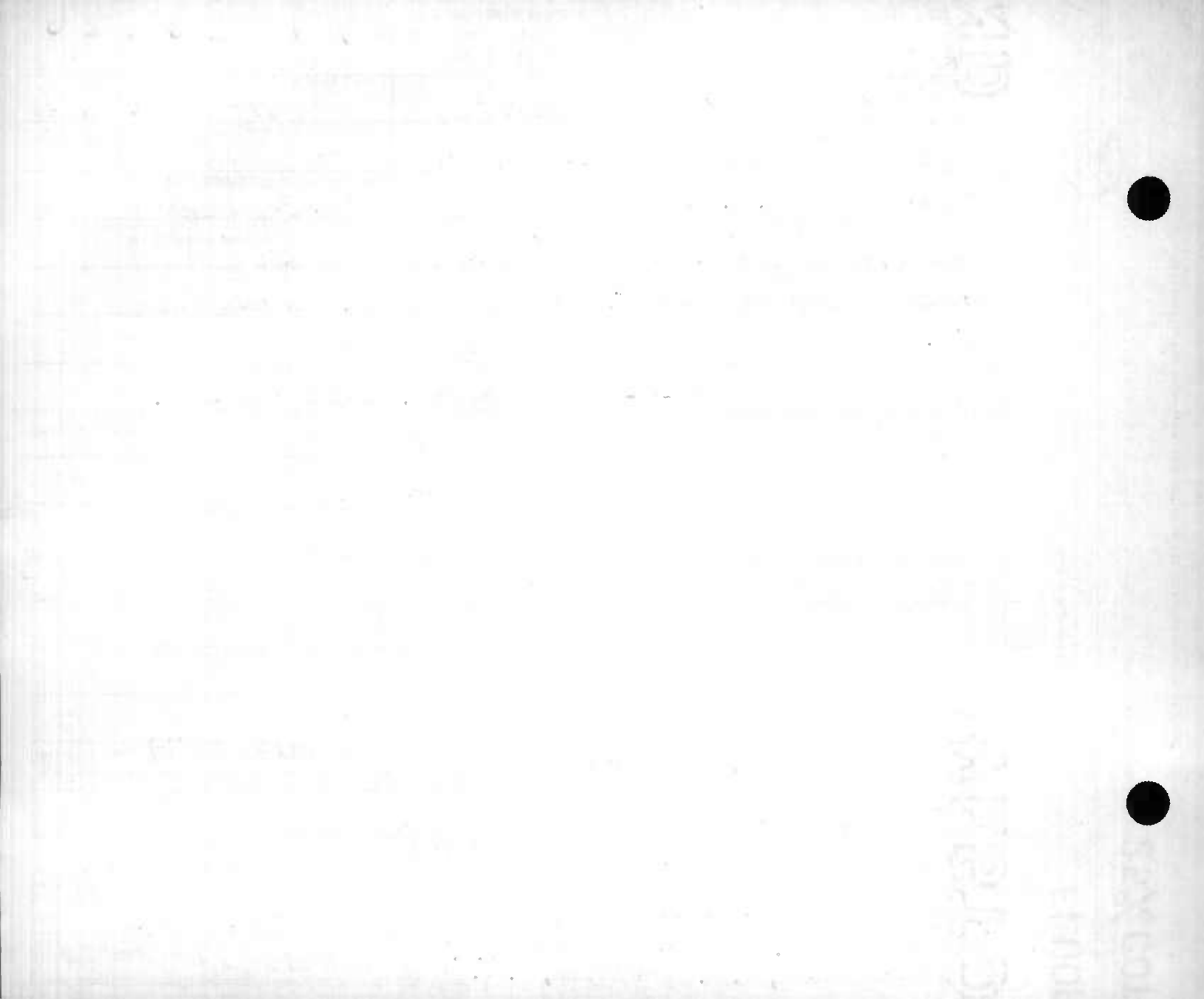
Washington, D.C. 20008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			FIRST MIDDLE LAST Betty R. Hurvitz		MONTH DAY YEAR 11-12-79	
3. SEX Female			4. RACE White		2b. HOUR 12 <sup>30</sup> A.M.	
5. DATE OF BIRTH MONTH DAY YEAR March 11, 1907			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 24 HRS HOURS MIN.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Silver Spring		13d. STREET ADDRESS 10009 Lorrain Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Pasternak			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Undiscernable			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-3672		17. INFORMANT ADDRESS Alexander S. Hurvitz Same as No. 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA COLON (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Gastrointestinal bleeding; Cerebral artery thrombosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/19 1979 to 11/12 1979, that (I) (we) last saw the deceased alive on 11/11 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Hubert J. Alpert M.D.				22c. DATE SIGNED 11/12/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, M.D.				22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD. 20910		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/14/1979		23c. NAME OF CEMETERY OR CREMATORY Beth Shalom Congregation Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hillside, Maryland
24. FUNERAL DIRECTOR'S NAME Donald M. Stein Hebrew Memorial F.H.				25a. DATE REC'D. BY REGISTRAR NOV 16 1979		25b. REGISTRAR'S SIGNATURE Hickey McBrady
232 Carroll Street, N. W. Washington, D. C.						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR					7 9 2 8 4 2 7					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					
Charles R. Irwin III INFANT BOY					11 24 79 6:13am					
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		
Male		white		Nov. 24, 1979		0 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Montgomery MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION								
Takoma Park		Washington Adventist Hospital								
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
N/A										
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.					P. Geo.		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Charles R. Irwin					Virginia M. Boudreau					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT			
N/A					N/A		Gerald J. Boudreau same as 13 a-c			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Immaturity</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Premature labor</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/24/79</u> , 19 <u>79</u> , to <u>11/24/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov. 22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
<u>Sontack Lee</u>								<u>11/26/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Sontack Lee		7600 Carroll Ave. Takoma Park, Md. 20012								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial		Nov. 29, 79		Resurrection Cem		Clinton, Maryland				
24 FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR								
Lee Funeral Home, Clinton, Maryland		25b. REGISTRAR'S SIGNATURE								

MEDICAL CERTIFICATION

2 9

135 71 35 160 2

1201



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 8 4 2 8			
1 - FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HARRY JENKIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11-13-79</b>				2b. HOUR <b>11 A</b> M			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 3, 1886</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS <b>11 13</b>		7 IF UNDER 24 HRS. HOURS MIN. <b>11 13</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.							
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TAILOR</b>		12b KIND OF BUSINESS OR INDUSTRY <b>GARMENTS</b>					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b> 13b COUNTY <b>PR. GEORGES</b> 13c CITY OR TOWN <b>BERWYN HEIGHTS</b> 13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						13e STREET ADDRESS <b>5821 RUATAN STREET</b>							
14 FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM ISAAC JENKIN</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH (UNKNOWN)</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I</b>		17 INFORMANT <b>SHIRLEY DONDES, same as #13</b>		ADDRESS							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1-2 wks</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>april</u> 19 <u>76</u> , to <u>Nov</u> 13, 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11-13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) did not view the body after death.													
22b SIGNATURE <u>S. B. Cushner, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11-13-79</b>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>GILBERT CUSHNER, M. D.</b>						22e ADDRESS <b>Suite 201 11161 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>11/14/1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>OHEV SHOLOM TALMUD TORAH CONGREGATION CEMETERY</b>				23d LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON D. C.</b>					
24 FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>						25 DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>							
26 ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>						27 REGISTRAR'S SIGNATURE <u>[Signature]</u>							







TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE KNOWN OF DEATH			MONTH DAY YEAR			21. HOUR			
Ruth			I. Jenkins			11/04/79			12:15			P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		24. HOUR	
Female		White		Aug. 17 1919		60 YRS.		MONTHS DAYS		HOURS MIN.		11-4-79		12:15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Ohio				USA								Montgomery County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Olney				Montgomery General Hospital				Clerk				Stitchery			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Montgomery				Sil. Spring				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO.				17. INFORMANT			
(Unknown)				(unknown)				291-30-5421				Oscar E. Jenkins-husband-(same as 13)			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				18b. SOCIAL SECURITY NO.				18c. CITY OR TOWN				18d. STREET ADDRESS			
no				none				291-30-5421				Oscar E. Jenkins-husband-(same as 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
22b. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
22c. I certify that I took charge of the remains described above, held on death resulted from: Actual Signature: <u>Richard L. Whelton</u> M.D. Deputy Medical Examiner															
22d. I certify that I took charge of the remains described above, held on death resulted from: EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON ADDRESS 700 Baltimore Ave College Park															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				11-9-1979				Memorial Park				WHEELERSBURG SCIOTO OHIO			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.				8434 G Ave. S.S. Md.				NOV 08 1979							

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Per file

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# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

## MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED BY THE MEDICAL EXAMINER OR AN ASSISTANT. THE CERTIFICATE SHOULD BE FILED IN THE MEDICAL RECORDS OF THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M7/77



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Alice Baker Johnston</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 4 79</b> 9 <b>PM</b>				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 14 82</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS MONTHS DAYS		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mo.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Mont. Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired -Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b> 13c. COUNTY <b>Montgomery</b> 13d. CITY OR TOWN <b>Sil.Sp.</b>					13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>204 Mowbray Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel E. Baker</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amanda H. Barker</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>376-32-2121D</b>		17. INFORMANT ADDRESS <b>Silver Spring, Md. 20904</b> <b>Harriet J. Arthur-daughter 204 Mowbray St.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspiration pneumonia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/24 19 79</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>11/24 19 79</b> to <b>11/4 19 79</b> , that (I) (we) last saw the deceased alive on <b>11/4 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Marian Chung, M.D.</b> DEGREE <b>M.D.</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11-5-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARIAN CHUNG, M.D.</b>					22e. ADDRESS <b>344 University Blvd. West. Silver Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11-6-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C. 20002</b>		
24. FUNERAL DIRECTOR <b>J. William Lee's Sons Co. 300-4th St. N.E. Wash. D.C.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 07 1979</b>		25b. REGISTRAR'S SIGNATURE <b>H. J. H. H.</b>		

BP

1. Will in Lee's Sons Co. 300-1st St. N.W. Wash. D.C.

Generation

11-0-7

Lee's Crematory

Washington, D.C. 20005

• 370-32-2121

370-32-2121

Director J. Arthur-son, 370-32-2121  
Silver Spring, Md. 20904

Samuel

B.

Baker

Martha R. Baker

Id.

Port • 370-32-2121

x

370-32-2121

Telephone

370-32-2121

370-32-2121



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 3 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ETTA H. Jones</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 19 1979</i>		2b. HOUR <i>8 A M</i>	
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 28 97</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.
10 CITY OR TOWN OF DEATH <i>Kensington</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Kensington Gardens</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <i>md.</i>			13b COUNTY <i>Pr A. A.</i>		13c CITY OR TOWN <i>Chroston</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>James Hardison</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Rouse</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>—</i>		16b SOCIAL SECURITY NO. <i>228-01-7798</i>		17 INFORMANT ADDRESS <i>Marjorie Mazingo 1433 Knights Bridge Turn</i> <i>Grofton, Md. 21114</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable acute myocardial infarction or ventricular arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>due to severe atherosclerotic heart disease</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>due to severe atherosclerotic heart disease</i>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>6-29</i> , 19 <i>79</i> , to <i>11/19</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/13</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Barry N. Rosenbaum, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>11/19/79</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BARRY N. ROSENBAUM</i>		22e. ADDRESS <i>3720 FARRAGUT AVE KENSINGTON, MD 20795</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>21 Nov 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Snow Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Snow Hill Green N, Carolina</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert G. Beall F.H. 9013 Annapolis Road Lanham, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 23 1979</i>		
				25b. REGISTRAR'S SIGNATURE <i>Henry M. Brady</i>		

MEDICAL CERTIFICATION







DHMH - 17  
(VR A13 ME (5))  
30M 7/73

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										7 2 8 4 3 3	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REGINALD D. JONES						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 11 20 1979		2b. HOUR M 10:24 P M			
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1962		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 20 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1801 Merrimac Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Jones						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Goodwyn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Hattie Jones (Mother) same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:50 PM 11-20-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object impact.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Biggs Rd. so. of Hyattsville, Montgomery Md. Bardonia Way					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 11-22-79			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 11-23-69		23c. NAME OF CEMETERY OR CREMATORY Johnson Funeral Home				23d. LOCATION CITY OR TOWN COUNTY STATE McKinney, Virginia	
24. FUNERAL DIRECTOR NAME George R. Snowden						25a. DATE FILED BY REGISTRAR NOV 26 1979					
246 N. Washington Street Rockville, Md. 20850											

BP  
5700

James P. Gowan, Secretary, No. 2082  
SAC, Washington Field  
11-23-60 Johnson Funeral Home  
Washington, D.C.

Latite Jones (Mother) same as #19

Latite Gowan

1801 Vermont Drive

Student

U.S.A.

Adelant

Mr. Geo.

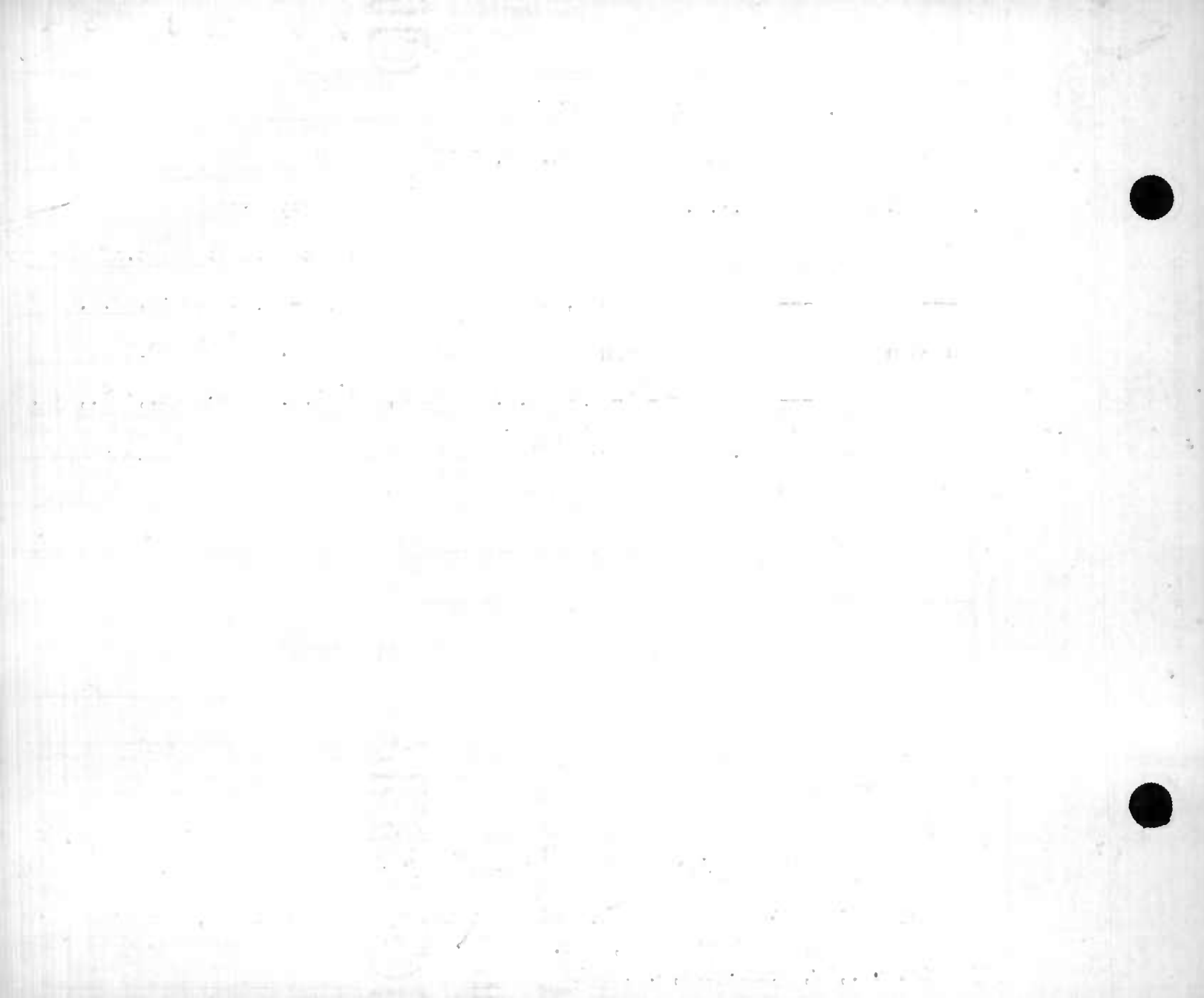
Robert Jones

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. <u>2843</u>		7 9 release 2843					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>W. WOODROW JONES</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>11/24/79</u>		2b. HOUR <u>7:05 P</u> M			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Oct. 27, 1912</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>67</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>S. Carolina</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>BETHESDA MD</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SUBURBAN HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Budget Analyst</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Air For</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Washington, DC</u>		13c. CITY OR TOWN <u>Washington, DC</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>5320 - 41st Street, N.W.</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Unknown</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Bertie Iddings</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>247-01-5662</u>		17. INFORMANT ADDRESS <u>R.C. Haglund, 882 N. Lexington St., Arl., Va.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of stomach c</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>extension into esophagus</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>4-5 mos</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>February 1955</u> to <u>24 Nov 1979</u> , that (I) (we) last saw the deceased alive on <u>24 Nov 1979</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.									
22b. SIGNATURE <u>Michel M. Healy MD</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/25/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michel M. HEALY, M.D.</u>				22e. ADDRESS <u>5411 W Cedar Ln, Bethesda, MD 20014</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/3/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood, Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u>				24b. ADDRESS <u>5130 Wis. Ave., NW, Washington, D.C. 20016</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 3 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Patrick McCready</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Info added 12/3/79 bal G538										STATE OF MARYLAND									
1- FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH										7 9 2 8 4 3 5									
1 DECEASED NAME										2a. DATE OF DEATH									
FIRST MIDDLE LAST										MONTH DAY YEAR									
Carl W. JUDISCH										November 7 1979									
3 SEX										4 RACE									
Male										Caucasian									
5 DATE OF BIRTH										6 AGE (IN YEARS LAST BIRTHDAY)									
1939										40									
MONTH DAY YEAR										YRS. MONTHS DAYS HOURS MIN.									
Aug. 14 1949																			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b CITIZEN OF WHAT COUNTRY?									
Rhode Island										USA									
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH									
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										Montgomery MD.									
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION									
Bethesda										National Naval Medical Center									
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b KIND OF BUSINESS OR INDUSTRY									
U. S. Navy																			
13a. STATE										13b. COUNTY									
Maryland										Talbot									
13c. CITY OR TOWN										13d. STREET ADDRESS									
Pilgham										Box 231, Wharf Road									
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST										FIRST MIDDLE LAST									
Carl Henry Judisch										Dorothy Heath									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b SOCIAL SECURITY NO.									
Yes										1961-79									
17 INFORMANT										ADDRESS									
Constance M. Judisch										See item 13									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Sepsis complicating metastatic carcinoma																			
0389																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																			
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a AUTOPSY?										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b TIME OF INJURY									
										HOUR A.M. MONTH DAY YEAR									
										P.M. 19									
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d INJURY OCCURRED										21e PLACE OF INJURY									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>										[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]									
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																			
21f LOCATION																			
STREET										CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from Sept. 29, 1979, to Nov. 6, 1979, that (I) (we) lost the deceased alive on Nov. 6, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																			
22b SIGNATURE										22c DATE SIGNED									
[Signature]										Nov. 8, 1979									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS									
D. B. COLVIN, M.D.										National Naval Medical Center, Bethesda, Md.									
23a BURIAL, CREMATION, REMOVAL										23b DATE									
Cremation										11/9/79									
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION									
Metropolitan Crematory Alexandria										CITY OR TOWN COUNTY STATE									
Virginia																			
24 FUNERAL DIRECTOR										25a. DATE RECEIVED BY REGISTRAR									
Metropolitan Funeral Service Alexandria Va.										25b. REGISTRAR'S SIGNATURE									
NAME ADDRESS																			







FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 3 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Edith Myra Kain</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-26-79</i>			2b. HOUR <i>11:10 P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 23, 1882</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>97</i> YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>England</i>		7b. CITIZEN OF WHAT COUNTRY? <i>England</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Bethesda</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>6206-Verne Street</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John - Powell</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ann - Unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-45-6215</i>		17. INFORMANT ADDRESS <i>Joan E. Kain (Daughter) Same as # 13</i>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic heart disease</i> <i>years</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial infarction &amp; degenerative heart</i> <i>years -</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Carcinoma right breast -</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <i>(the hospital)</i> attended the deceased from <i>11/2</i> 19 <i>79</i> to <i>11/26</i> 19 <i>79</i> , that (I) <i>(last)</i> saw the deceased alive on <i>11/26</i> 19 <i>79</i> , and that in (my) <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(do)</i> (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>			DEGREE <i>MD</i>			22c. DATE SIGNED <i>11/27/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>T.W. BRENNWALD</i>			22e. ADDRESS <i>831 University Blvd E, Silver Spring</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>Nov. 27, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>		
24. FUNERAL DIRECTOR NAME <i>J. Wm. Lee's Sons Co.</i>					ADDRESS <i>300-4th St., NE, Wash., D.C.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 30 1979</i>		
							25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 3 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Elroy Ralph Kauffman</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11-23-79</b>		2b. HOUR <b>1:13</b> <small>a.m.</small>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-13-04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D C</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Assoc. Safeway Employees</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2105 Woodberry Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>E. T. Kauffman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Souders</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-05-1853</b>		17. INFORMANT ADDRESS <b>Charlotte W. Kauffman (w wife) same as 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 7 1979</b> to <b>Nov 19 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov 7 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Boris Rabin</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-23-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BORIS RABIN M.D.</b>				22e. ADDRESS <b>1009 Univ. Blvd East St. Louis</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. G. eo's Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>							

100

11-23-73

Memorandum

TO: Mr. Tolson

FROM: Mr. [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum body containing several paragraphs of text.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR  
1 -  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 3 8

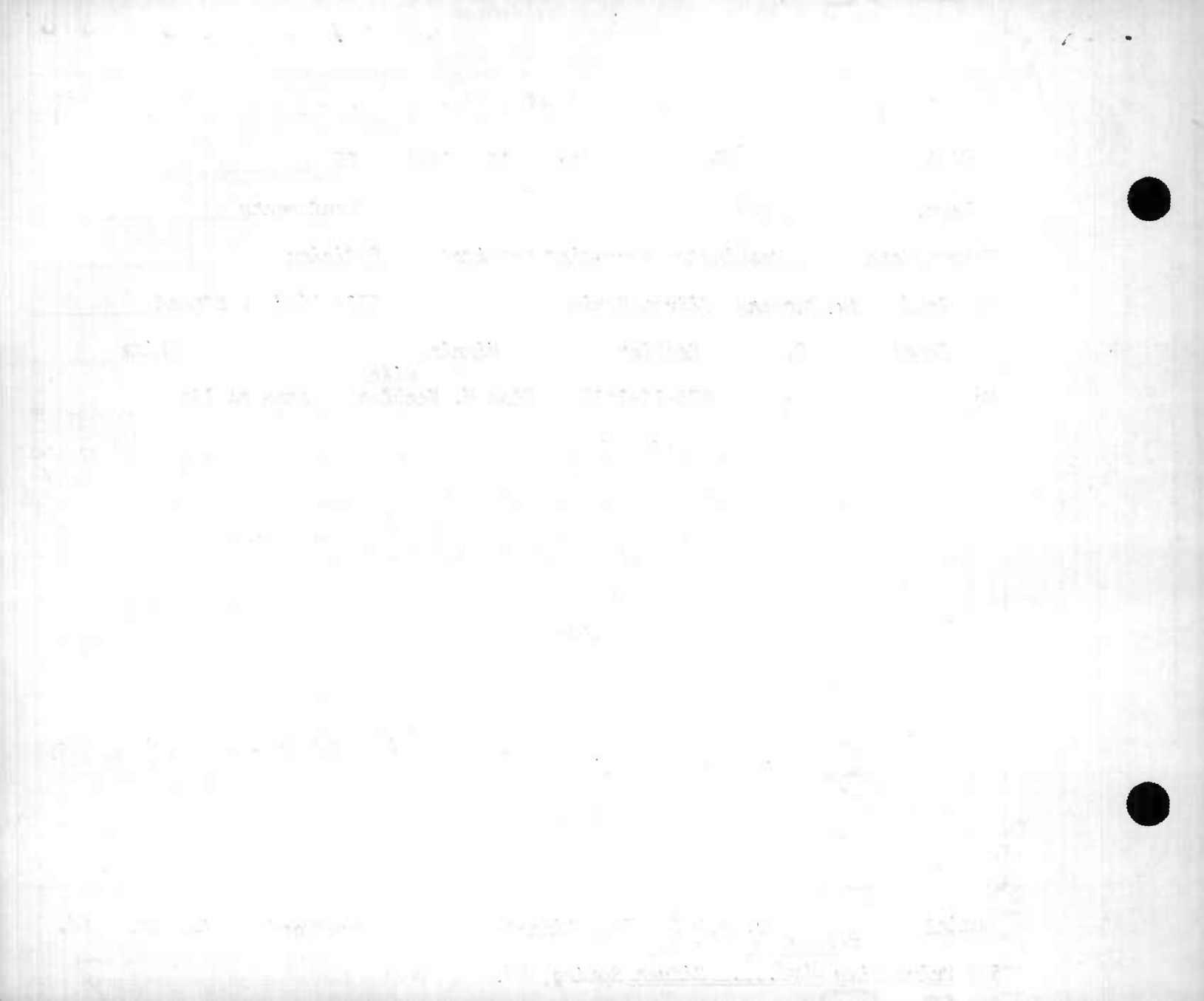
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>James Houston Keebler</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>11-22-1979</u>			2b. HOUR <u>1:00</u> A M			
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>May 16 1904</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Tenn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.		
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Optician</u>			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>James G. Keebler</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Minnie White</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>578-12-1815</u>		17. INFORMANT <u>wife</u>			ADDRESS <u>same as 13c</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypotension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
4414 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u>		<u>2 weeks</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure</u>		<u>2 weeks</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Uremia, jaundice, ileus</u>			
19a. DATE OF OPERATION <u>Oct 29, '79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Resection abd. aneurysm</u>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 25 1979</u> to <u>Nov 22 1979</u> , that (I) (we) last saw the deceased alive on <u>Nov 22 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.			
22b. SIGNATURE <u>John C Barr, MD</u>		22c. DATE SIGNED <u>Nov 22, '79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John C Barr, MD</u>		22e. ADDRESS <u>10500 Summit Ave, Kensington, Md</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 26, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood Pr. Geo. Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 27 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Robert McBrady</u>	
500 University Blvd., W. Silver Spring, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO. 7 9 2 8 4 3 9					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST MARY MIDDLE Elizabeth LAST KENNEDY				MONTH 11 DAY 6 YEAR 79				305 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		MONTH 7 DAY 23 YEAR 01		78 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Homemaker		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE MARYLAND 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1020 Bradley Avenue			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST John MIDDLE Windish LAST				FIRST Elizabeth MIDDLE Greenwald LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				198 48 7651		414 Mercer Ave. Turtle Creek, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2506 DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Gangrenous toes</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				P.M. 19				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> 19 <u>79</u> , to <u>11/6</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/5</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B.S. Kim</u>				DEGREE				22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				11/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KWANG SUH KIM</u>				22e. ADDRESS <u>615 W. Montgomery Ave. Rockville MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR PLACE OF BURIAL		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		11/9/79		Braddock Catholic		Braddock Hills, PA			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND				NOV 9 1979		<u>Robert A. Pumphrey</u>			



35

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 8 4 4 0			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE N. KENNEDY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 20 '79</b>		2b. HOUR <b>4:10 P</b>	
3 SEX <b>Female</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 10 1929</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> YES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b> 13b. COUNTY <b>MONT</b> 13c. CITY OR TOWN <b>Bethesda</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7812 Glenbrook Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO <b>128-00-7473</b>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>436 -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>11/10/79</b> to <b>11/20/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thos G. Ward</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/20/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. Ward</b>				22e. ADDRESS <b>6116 Robinwood Bethesda, Md 20834</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. ...</b>	

88

WHITE

MONTGOMERY

x

SUBURBAN HOSPITAL

BETHESDA

128-00-7473

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY L. KENNY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-23-79</b>		2b. HOUR <b>649</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 28 1908</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> 76 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN <b>Maryland Newt. Silver Spring</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>2702 Sheraton St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry R. Kenny</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charles G. Brainerd</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>518-05-9216A</b>	17. INFORMANT ADDRESS <b>James Kenny 13c</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Irreversible shock &amp; renal failure</b> DAYS <b>4288</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cran. negative septum</b> DAYS (c) <b>Cardiopulmonary failure &amp; congestive</b> DAYS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  
**Dehydrating fluids - anaphylactic shock**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov-6</b> 19 <b>79</b> , to <b>Nov-23</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11-22</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)			
22a. SIGNATURE <b>Albert H. Grollman MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>11/23/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT H. GROLLMAN MD</b>		22e. ADDRESS <b>106 SPRING ST. SILVER SPRING MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>Nov. 24-1979</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>
24. FUNERAL DIRECTOR NAME <b>Arthur Walters</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Marking McCready</b>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITALS: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

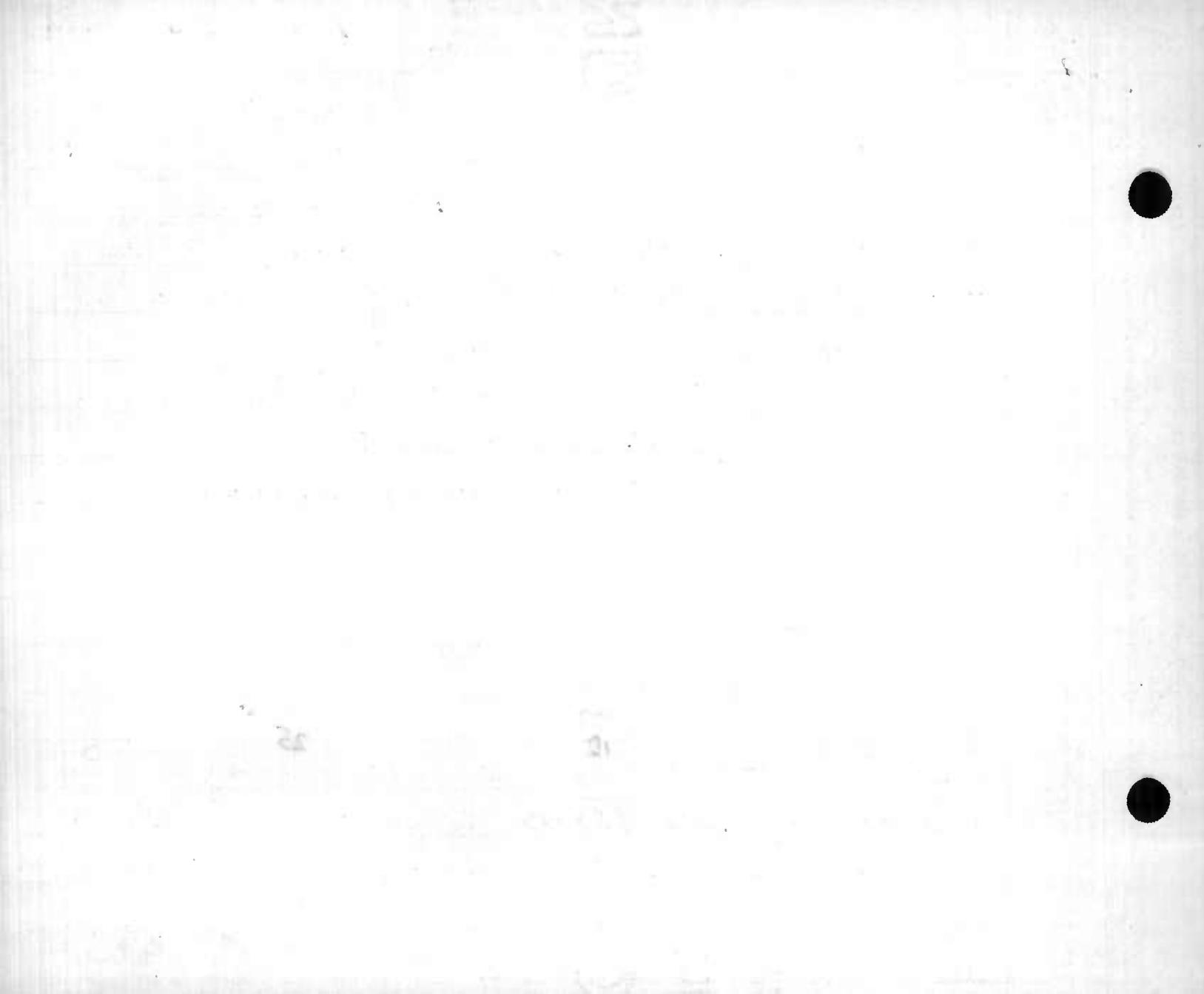


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) Eva E. Kershaw					2a DATE OF DEATH MONTH DAY YEAR Nov. 25, 1979			2b HOUR 8:35A M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b KIND OF BUSINESS OR INDUSTRY Retired		
13a STATE Maryland					13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Kershaw					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Johnson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 215-03-8186		17 INFORMANT ADDRESS 216 Williamsburg Dr. Ann K. Kurtz Silver Spring, Md. 20901						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction &amp; extension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a DATE OF OPERATION none		19b CONDITION FOR WHICH OPERATION WAS PERFORMED none			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (a) (this hospital) attended the deceased from <u>10-25-79</u> , 19____, to <u>11-26-79</u> , 19____, that (b) (we) lost saw the deceased alive on <u>11-26-79</u> , 19____, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Charles Franklin Jr</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 11-26-79				
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles L Franklin Jr				22e ADDRESS 11200 Rockwood Dr Silver Spring Md 20901						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov. 27, 79		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montg., Md.				
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				25a DATE REC'D. BY REGISTRAR DEC 03 1979		25b REGISTRAR'S SIGNATURE <u>Richard McCreedy</u>				
11800 New Hampshire Ave. Silver Spring, Md.										





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 2 8 4 4 3		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carl nmn Keys</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11/30/79</b>		2b. HOUR <b>8:48a</b>	
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/26/28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Building Maint.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School Board</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl Lynn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amanda Keys</b>		13e. STREET ADDRESS <b>130 Ames Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-26-0110</b>		17. INFORMANT ADDRESS <b>Gladys Keys (wife) same as #13</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured pulmonary vessel</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of the Lung &amp; involvement of</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>The chest vessels</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 3 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>Oct 14</b> , 19 <b>79</b> , to <b>11 30</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>11-26-79</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)							
22b. SIGNATURE <b>Charles L Franklin Jr</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-30-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles L Franklin Jr</b>		22e. ADDRESS <b>11202 Lockwood Dr. Silver Spring Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-4-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montg. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		246 N. Washington Street <b>Rockville, Md. 20850</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. [Signature]</b>	

11/30/73 10:43

12/1/73 10:43

52

2126128

white

male

Washington

12/1/73

Building, 1st. School, 1st

Washington Adventist Hospital

12/1/73

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Items 23c, 23d, 5338 12/6/79 g1

FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28444

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		24 HOUR	
Myron		J		Kieffer				11		26		19		23		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	12 DAY 2		1919		38 YRS.				11		26		19		23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
NEW YORK		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		Holy Cross Hosp		U.S. GOVERNMENT													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Silver Spring		NO <input checked="" type="checkbox"/>		600 Stonington Rd									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
JOSEPH		KIEFFER		BARBARA		BAUMAN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		WW II		118-07-1064		SARAH C. KIEFFER		SAME AS 13		WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		(b) <u>Chronic Myocardial Dis.</u> 4291 DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		4 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
None																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED		Nov. 26 1979							
EXAMINER'S NAME (TYPE OR PRINT)		JOHN S. ROGERS		ADDRESS		SILVER SPRING, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		11/29/79		Arlington National Cem		Arlington		MONT		MD.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
FRANCIS J. COLLINS		NOV 27 1979		John S. Rogers													
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					7 9 2 8 4 4 5				
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Esther P. Klossner					Nov. 5 1979				
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		Feb. 2 1894		85		9:30 am	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS DAYS HOURS MIN.	
Indiana		U. S. A.				Montgomery			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Congressional Country Club				Self-Employed		Musician	
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
Md					Montgomery		Bethesda		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Unknown					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
No					Unknown		Jane Maisch, Friend. 7805 Cindy Lane, Bethesda, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 515- CONGESTIVE HEART FAILURE									
DUE TO, OR AS A CONSEQUENCE OF (b). PULMONARY FIBROSIS									
DUE TO, OR AS A CONSEQUENCE OF (c).									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1969 to 5 Nov 79, that (I) (we) lost saw the deceased alive on 1 Nov 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. A. Grennan					MD		Nov. 5, 1979		H. Arthur Grennan M. D.
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
H. Arthur Grennan M. D.					1145 19th ST. N. W. Wash., D. C. 20036				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			11/8/1979		Cedar Hill Cemetery		Suitland, Maryland		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons Inc. 5130 Wisc Ave N.W. DC						NOV 09 1979		Dorothy McCreedy	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARY AGNES KOLB</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/14/79</b>		2b. HOUR <b>6:05 A.M.</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 8, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH. D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONT.</b> 13c. CITY OR TOWN <b>BETHESDA</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8502 RAYBURN ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LAURENCE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA COOK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-01-2055</b>		17. INFORMANT ADDRESS <b>937 N. EDGEWOOD ST. ARL. VA</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>chronic congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>arteriosclerotic coronary heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>diabetes mellitus - probable metastatic carcinoma of breast</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the medical examiner) attended the deceased from <b>Feb 19, 79</b> , to <b>11/4, 1979</b> , that (I) (we) lost saw the deceased alive on <b>11/14, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>John O. Allin M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11.14.79</b>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John O. Allin M.D.</b>		22c. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Md. 20014</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HolyRood Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASH. D.C.</b>		24. FUNERAL DIRECTOR NAME <b>John F. DeLoi</b> ADDRESS <b>WASH. D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		
25b. REGISTRAR'S SIGNATURE <b>Richard A. Bandy</b>						



10

June 2 Monday July 11

July 11 Tuesday July 12

Montgomery

July 12 Wednesday July 13

July 13 Thursday

July 14 Friday July 15 Saturday

July 16

July 17

July 18

July 19

July 20 Sunday July 21 Monday

WESTO

July 22 Tuesday July 23 Wednesday

July 24 Thursday

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 4 7

REG. NO.

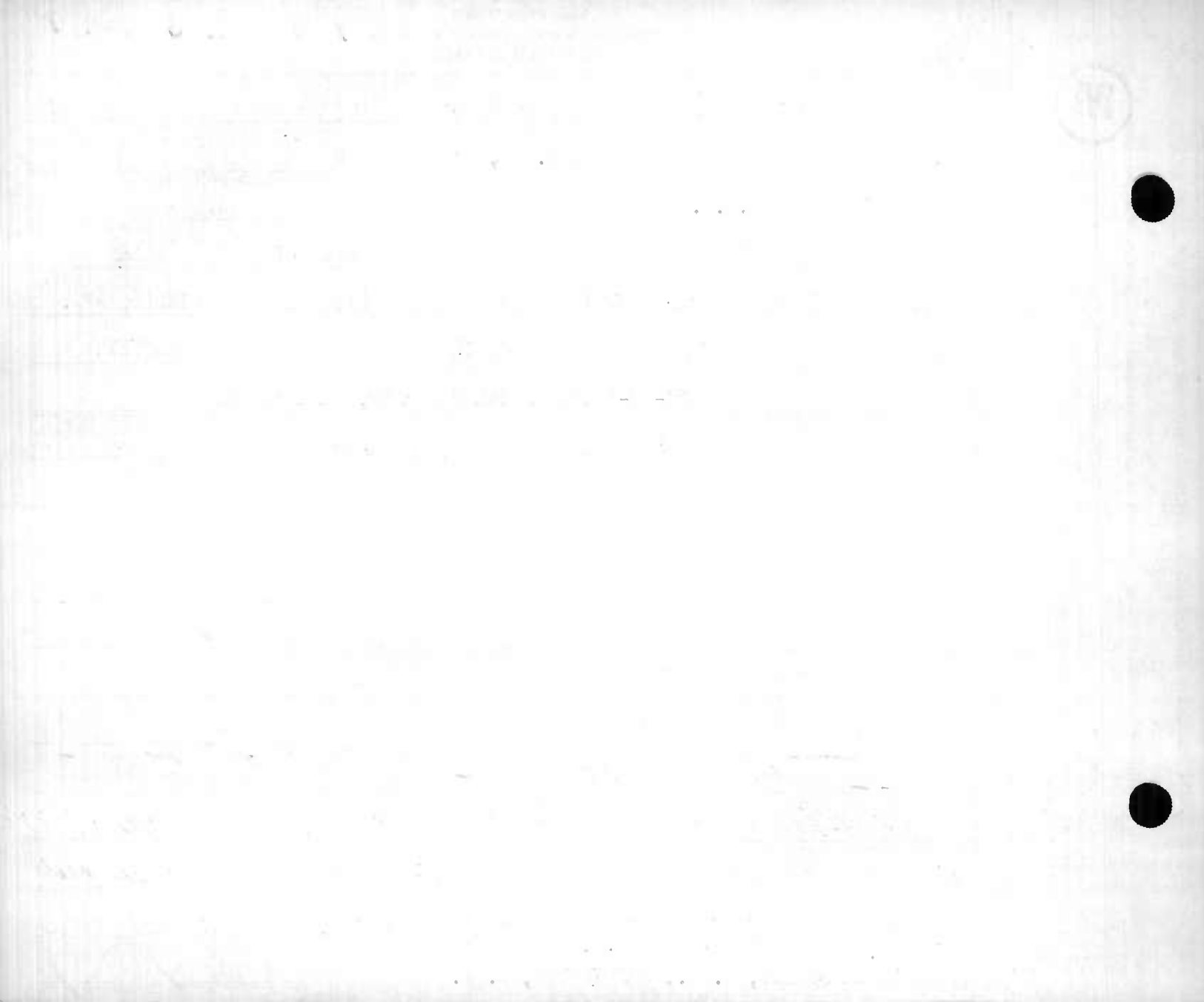
1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT J KRAMER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11/08/79</b>		2b. HOUR <b>5:10 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 1, 1909</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		10. CITY OR TOWN OF DEATH <b>Silver Springs</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>	
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>		13. KIND OF BUSINESS OR INDUSTRY <b>SALES</b>		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>SILVER SPRING</b>	
15. FATHER'S NAME FIRST MIDDLE LAST <b>PAUL KRAMER</b>		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE GOLDSTEIN</b>		17. STREET ADDRESS <b>2386 GLENMONT CIRCLE, APT. 203</b>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		19. SOCIAL SECURITY NO. <b>578-03-9269A</b>		20. INFORMANT ADDRESS <b>SHIRLEY KRAMER, same as #13</b>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>malignant melanoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <b>6 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		22f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22g. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		22h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22j. I certify that (I) <del>the hospital</del> attended the deceased from <b>NOV 8</b> , 19 <b>79</b> , to <b>NOV 8</b> , 19 <b>79</b> , that (I) <del>was</del> lost saw the deceased alive on <b>NOV 8</b> , 19 <b>79</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> did not view the body after death.					
22k. SIGNATURE <b>Walter E. G. M. M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22l. DATE SIGNED <b>NOV 9, 1979</b>	
22m. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER 60024 MD</b>		22n. ADDRESS <b>8309 SHOREFIELD RD WHEATON MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/11/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GARDENS</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>OLNEY MONTGOMERY MARYLAND</b>		23e. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		23f. REGISTRAR'S SIGNATURE <b>Walter E. G. M. M.D.</b>	
24. FUNERAL DIRECTOR <b>DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 4 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Melanie KREKEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 10, 1979</b>		2b. HOUR <b>11:08p</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 8, 1962</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>17</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>High School student</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Virginia</b>			13b. COUNTY <b>Fairfax</b>	13c. CITY OR TOWN <b>Falls Church</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lyman Edward Krekel</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Jo Anderson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>231-15-6692</b>		17. INFORMANT ADDRESS <b>Lyman E. Krekel, See #13</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure Due to Complicating</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF <b>Metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>April 23, 1979</b> to <b>Nov 10, 1979</b> , that (b) (we) lost saw the deceased alive on <b>Nov 10, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jeffrey M. Crane</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>Nov. 11, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey M. Crane</b>		22e. ADDRESS <b>NMMC, Bethesda, Md. 20014</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/14/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR NAME <b>MURPHY F.H.</b>		ADDRESS <b>1102 W. BROAD ST. F.C. VA.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>	
25b. REGISTRAR'S SIGNATURE <i>Murphy F. H. Murphy</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the body is released.



November 10, 1978

November 10, 1978

November 10, 1978

November 10, 1978

November 10, 1978

November 10, 1978

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

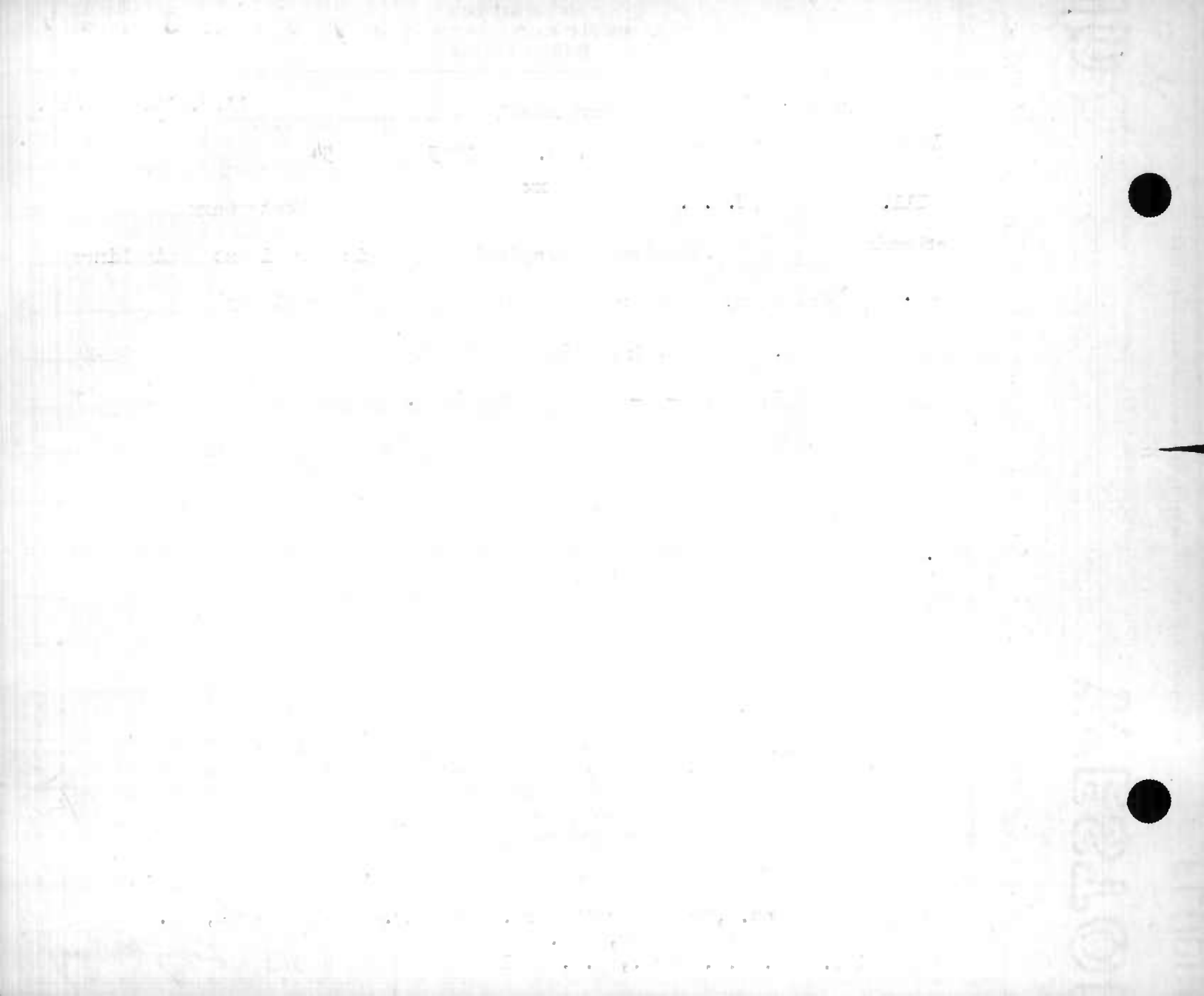
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

NOTE: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Medical Examiner's Office

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
John R. Kuykendall		11.5. 79.				8:22P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
Male	White	Jan. 16 1925		54 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ill.	U.S.A.			Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Suburban Hospital			Vice President			Ship Lines		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Montgomery		Sumner		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5606 WOOD Way	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT ADDRESS			
John R. Kuykendall			Mattie Coates						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Yes			WW II			338-16-7258			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY			19. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
IMMEDIATE CAUSE (a) Cardiac Arrest			338-16-7258			Marcella E. Kuykendall Same As Item # 13			
4140									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 12/27 1977 to 11/1 1979, that (I) (we) last saw the deceased alive on 11/1 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22a. SIGNATURE		DEGREE		22b. DATE SIGNED					
David W. SHKAR, MD		ATTENDING PHYSICIAN		11/6/79					
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS							
David W. SHKAR, MD		5401 Western Ave N.W. WDC 20015							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Nov. 8, 1979		Nat'l. Mem. Park Cem.		Falls Church, Va.			
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME 5130 Wisc. Ave. N.W. Wash., D.C. 20016				NOV 13 1979		History/Robbery			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>DOROTHY LACK</b>		2a DATE OF DEATH MONTH DAY YEAR <b>11-22-79</b>		2b HOUR <b>8:10 PM</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>3-16-1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MALTA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4601 Maple Ave.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst. to Commissioner U.S. Commerce</b>	
13a STATE <b>MD</b>		13b COUNTY <b>MONTGOMERY</b>		13c STREET ADDRESS <b>4601 MAPLE AVE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK LACK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fanny BLASDELL</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b SOCIAL SECURITY NO. <b>055-09-5587</b>		17 INFORMANT <b>Stephen White</b>		Box <b>35</b> <b>Childs, W.Va.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>20 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ <b>N/A</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>N/A</b>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 5, 1979</b> to <b>Nov. 22, 1979</b> , that (I) (we) last saw the deceased alive on <b>Nov. 22, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. Morell</b>				22c. DATE SIGNED <b>11-22-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EVA M. MORELL</b>				22e ADDRESS <b>7932 Old Georgetown Rd. Bethesda</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Nov. 23, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Va.</b>		24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>					



SEARCHED INDEXED

RECEIVED

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

RECEIVED

NOV 15 1979  
FBI - NEW YORK  
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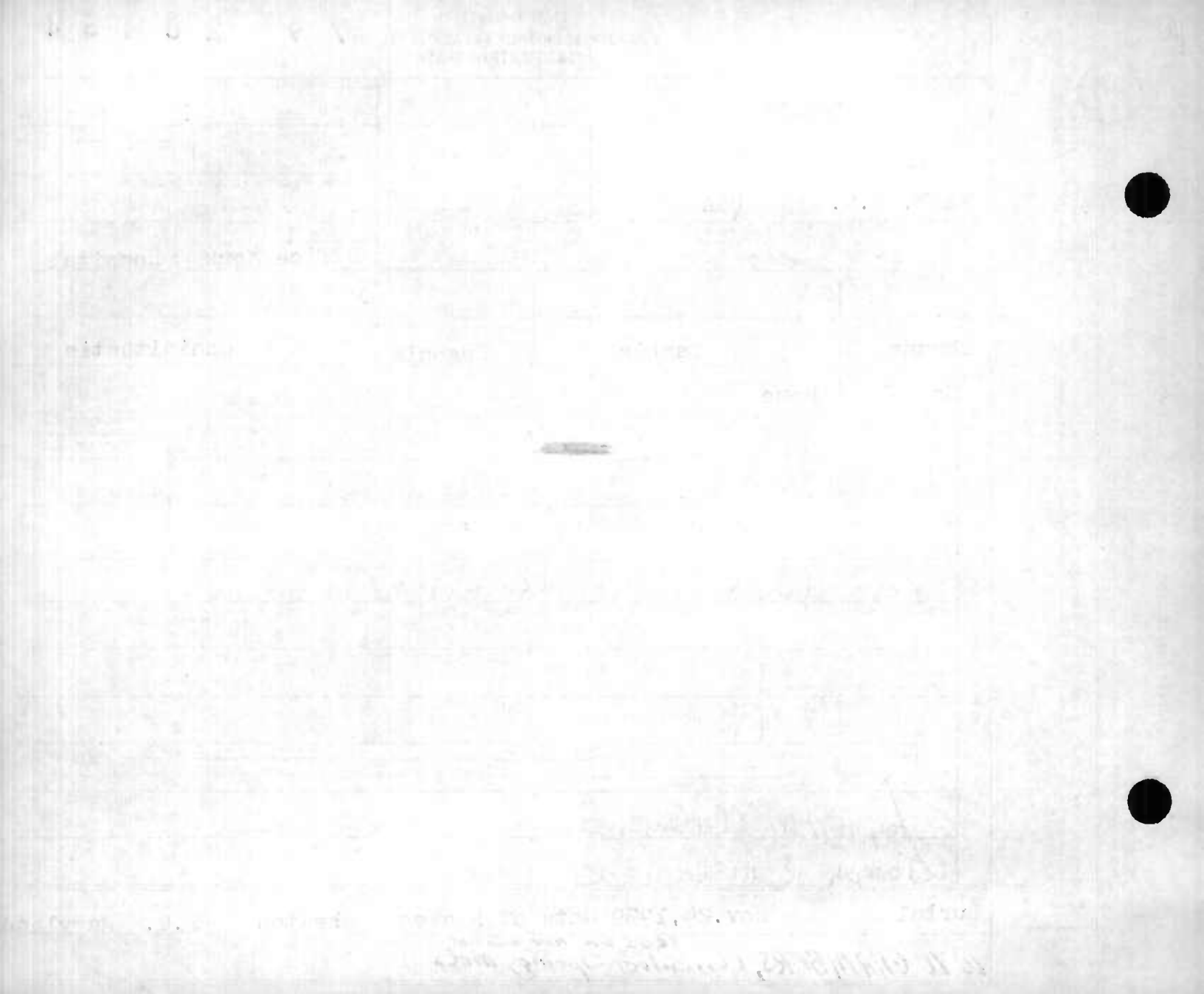
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Nicholas Lambis</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 20, 1979</b>			2b. HOUR <b>8:50 P<sup>M</sup></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 1, 1952</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>27</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Wash, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, Bethesda, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Work</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Lambis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eugenia Goniditostis</b>		13e. STREET ADDRESS <b>7910 13th St., N.W. 20012</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-52-3639</b>		17. INFORMANT ADDRESS (same as above) <b>Mrs. Virginia Lambis, mother</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock, cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recurrent ventricular Tachycardia, cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Thalassemia, hemosiderosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Respiratory failure, renal failure, heart failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>October 9, 1979</b> to <b>November 20, 1979</b> , that <b>x</b> (we) last saw the deceased alive on <b>November 20, 1979</b> , and that in <b>xx</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>xx</b> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph R. McClellan MD</b>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph R. McClellan</b>		22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>Nov. 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wheaton P.G. Maryland</b>			
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS, CO., Silver Spring, Md.</b>		24b. ADDRESS <b>8655 GA. AVE. S.W. MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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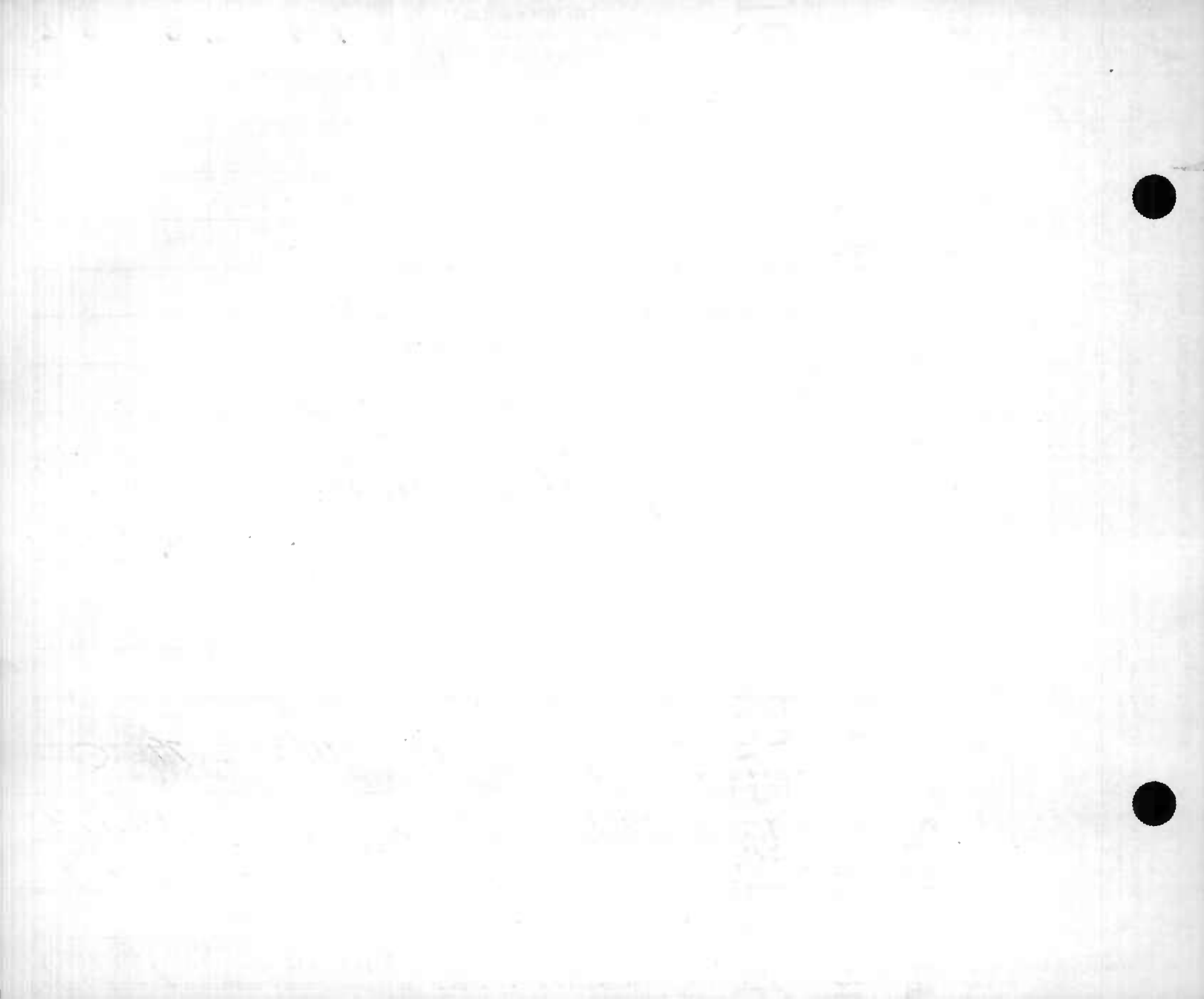
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12 71 35 2 9 9 1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				7 9 2 8 4 5 2 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GEORGE HADLE LANDES</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 3 1979</b>		2b. HOUR <b>6:28 PM</b>			
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 1 1894</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>85</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Arkansas</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Adventist Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>US Govt.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b. COUNTY 13c. CITY OR TOWN <b>Md PG T.P.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>7801 Cole Ave</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas R. Landes</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy A. Warren</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWI</b>				16b SOCIAL SECURITY NO. <b>579 09 8396A</b>		17 INFORMANT ADDRESS <b>Marie Landes (Wife) Same as above</b>			
II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of lung; recurrent 3 yrs</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden 1 wk</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>ASHD, cerebral arteriosclerosis</b>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <b>10/26</b> 19 <b>79</b> to <b>11/3</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>11-2</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John L Ford MD</b>				DEGREE		22c. DATE SIGNED <b>11/3/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN L FORD</b>				22e ADDRESS <b>394 University Blvd W Silver Spring Md 20901</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood PG Md</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Harry McCready</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

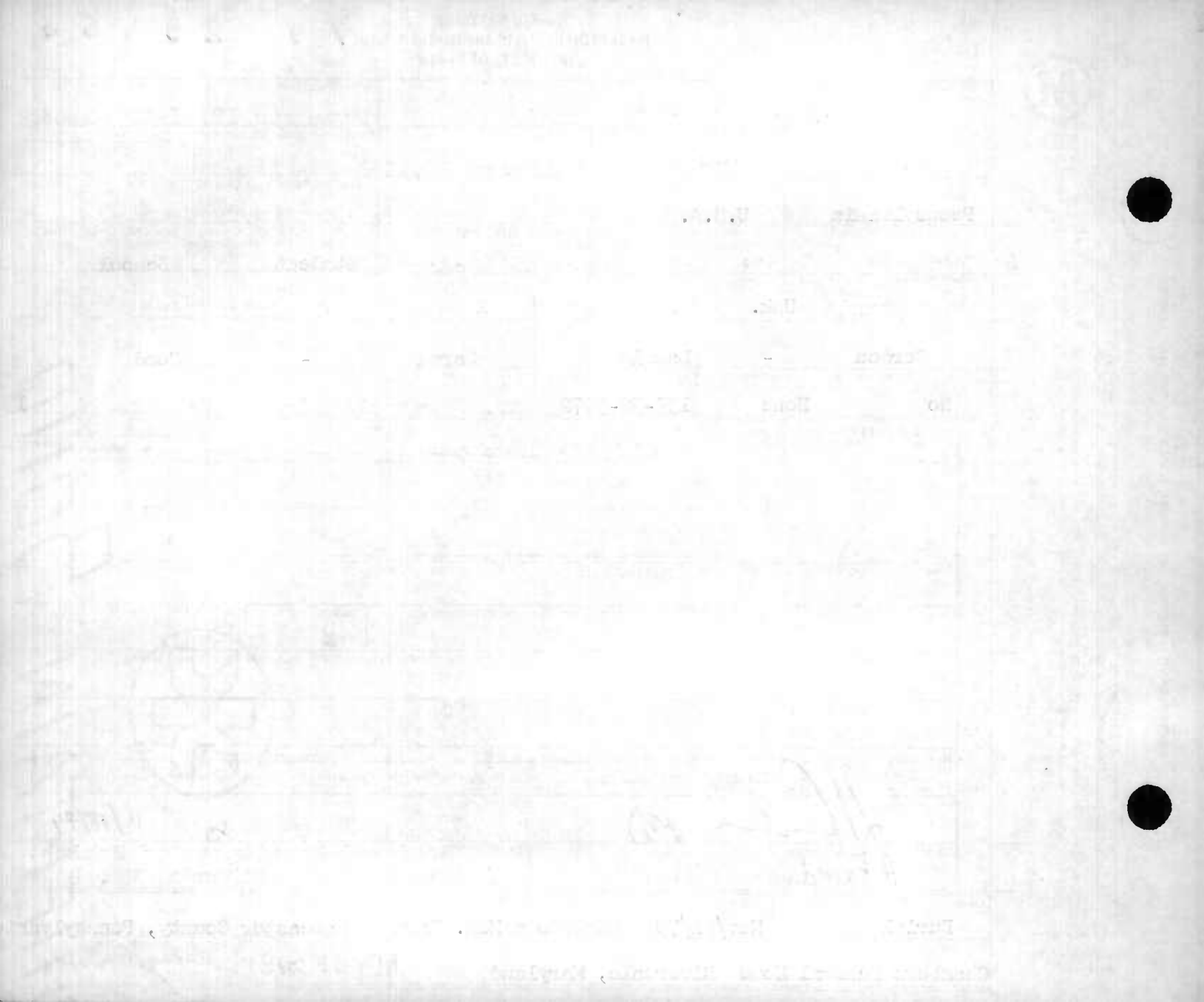
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 8 4 5 3  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Jeffrey Scott Landis		MONTH DAY YEAR November 18, 1979	
3 SEX Male		2b. HOUR 2:05pm	
4 RACE White		6 AGE (IN YEARS LAST BIRTHDAY)	
5. DATE OF BIRTH MONTH DAY YEAR February 10, 1965		14 YRS 14	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, Clinical Center, Bethesda, Md.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pennsylvania		13b. CITY OR TOWN E. Petersburg	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 6497 Miriam Circle 17520	
14 FATHER'S NAME FIRST MIDDLE LAST Gordon - Landis		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah - Good	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None		16b. SOCIAL SECURITY NO. 159-52-5972	
17 INFORMANT Mr. Gordon Landis		ADDRESS Same as above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burkitt's Lymphoma 2002 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (x) (this hospital) attended the deceased from August 2, 1979, to November 18, 1979, that x (we) lost saw the deceased alive on November 18, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we feel that we view the body after death.)			
22b. SIGNATURE H. Friedman MD		22c. DATE SIGNED 11/18/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Friedman MD		22e. ADDRESS National Institutes of Health, Clinical Center, Bethesda, Md. 20205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov/21/79	
23c. NAME OF CEMETERY OR CREMATORY Conestoga Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Lancaster County, Pennsylvania	
24 FUNERAL DIRECTOR NAME Chambers Funeral Home Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 23 1979	
25b. REGISTRAR'S SIGNATURE H. Friedman			





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28454	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Frances A. Lastique</b>										2a. DATE KNOWN OF DEATH ESTI. MATED <b>11-2-1979</b> MONTH DAY YEAR	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 12, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>70</b>		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>11-2-1979</b>		2b. DATE KNOWN OF DEATH ESTI. MATED <b>11-2-1979</b> MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>So. Car.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Kensington</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3213 Fayette Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic (Ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3213 Fayette Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leroy Young</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabelle Williams</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>113-12-8030</b>		17. INFORMANT ADDRESS <b>Karabelle Pizzigati, Daughter SAA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crown's Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Richard L. Whelton</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>Nov 3, 1979</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>RICHARD L. WHELTON</b>				ADDRESS <b>7100 Baltimore Ave College Park Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>New York, N. Y.</b>			
24. FUNERAL DIRECTOR <b>John F. Bolden</b>				ADDRESS <b>7400 Ga. Ave., NW</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 5 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILFRED HAMP LEE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 3, 1979</b>		2b. HOUR <b>11:36PM</b>		
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 27, 1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN <b>42</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE CLINICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>P.G. Co.</b>		13c. CITY OR TOWN <b>HILLCREST</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>3826 26th AVENUE 20031</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>William F. Lee</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret - Hensley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>'61/'64</b>		17. INFORMANT <b>MRS. EVA POWELL</b>		ADDRESS <b>1821 S STREET, NW WASHINGTON, DC 20009</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory insufficiency secondary to massive metastases to lung.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic melanoma, multiford ascites (11 liters)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>(11 liters)</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from <b>OCTOBER 11, 1979</b> to <b>NOVEMBER 3, 1979</b> , that (we) last saw the deceased alive on <b>NOVEMBER 3, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard I. Fisher</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/5/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard I. Fisher</b>				22e. ADDRESS <b>NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov./7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Veteran's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, P.G. Co, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chambers Funeral Home Riverdale, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert McCurdy</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BH

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## STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

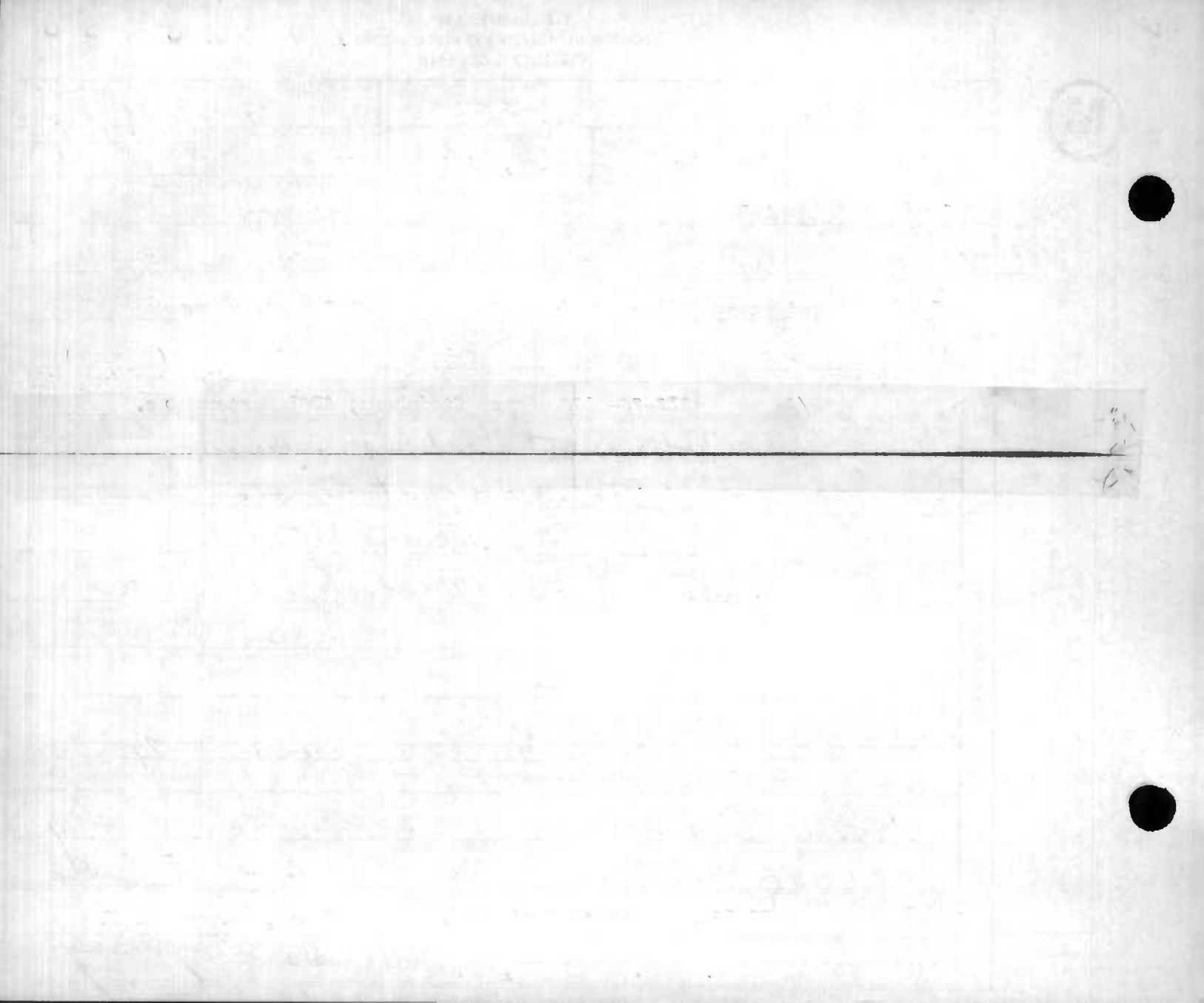
## CERTIFICATE OF DEATH

7 9 2 8 4 5 6

1. FOR  
STATE  
REGISTRAR

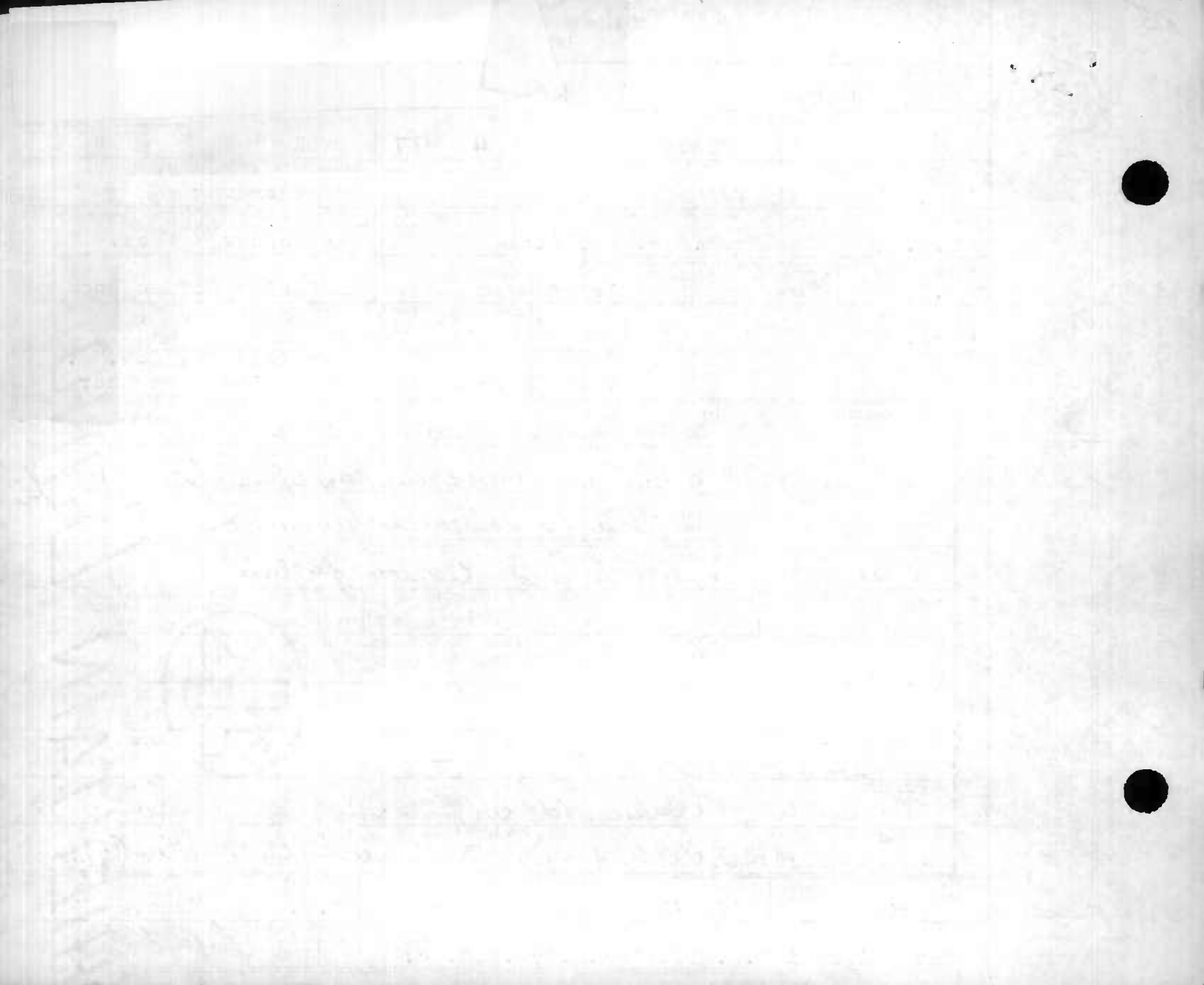
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IDA LEFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-13-79</b>			2b. HOUR MIN. <b>8:05</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 6, 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>89</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Poland</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8101 Eastern Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David ----- Meyerson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Toby Riva (Unknown)</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No N/A</b>					
16b. SOCIAL SECURITY NO. <b>213-74-0109</b>		17. INFORMANT ADDRESS <b>Mayer Steinberg, 8101 Eastern Ave. Silver Spring, Md.</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atherosclerotic (Arteriovascular Disease)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <b>Severe Senile Dementia; Myocardial Ischemia</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-9</b> , 19 <b>79</b> , to <b>11-13</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Arthur A. Davis</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/14/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR A. DAVIS</b>		22e. ADDRESS <b>8200 76th N.W. D.C.</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11-15-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elmont, Queens, N. Y.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>DANZANSKY-GOLDBERG MEM. CHAP. ROCKVILLE, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					





1. DECEASED NAME (TYPE OR PRINT) <b>Joseph</b>		FIRST MIDDLE LAST <b>Lenzi</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>27</b> YEAR <b>79</b>		2b. TIME OF DEATH <b>8:55 P.M.</b>	
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>4</b> YEAR <b>97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Monte Carlo</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>T.P.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Adv. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bartender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>#5 Spring Garden Road</b>	
13a. STATE <b>N.Y.</b>		13b. COUNTY <b>Long Island</b>		13c. CITY OR TOWN			
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE LAST <b>Lenzi</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Marie</b> MIDDLE <b>Ferrari</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>097 07 1893</b>		17. INFORMANT <b>405 Deerfield Rd. S.S.Md.</b> <b>A Jacqueline Fino Step-Daughter</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest 2° to</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arteriosclerotic heart disease, congestive failure years</b> (c) <b>right sided lower lobe pneumonia</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic glomerulonephritis and hepatic failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>11/8</b> , 19 <b>79</b> , to <b>11/27</b> , 19 <b>79</b> , that (I) <del>(we)</del> lost <del>saw</del> the deceased alive on <b>11/27</b> , 19 <b>79</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death.							
22b. SIGNATURE <b>Frederic W. Rinaldi MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>11/28/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.W. RINALDI</b>				22e. ADDRESS <b>231 University Blvd E, Blue Spring</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN <b>S.S. Mont. Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b> ADDRESS <b>11800 N.H.Ave.S.S.Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DECO 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		79-28458								
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROSE		MIDDLE O		LAST LEVIN		2a. DATE OF DEATH MONTH DAY YEAR 11-27-79		2b. HOUR 11:50A-M
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 8, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD HOUSE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6530 DEMOCRACY BOULEVARD		
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL BENEDICT OPPENHEIM				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH FISHBEIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 080-20-7525		17. INFORMANT THEODORE H. LEVIN,		ADDRESS 4920 SENTINEL DRIVE, SUMMER, MARYLAND 20016				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Complete heart block; polycythemia vera</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>72</u> , to <u>27 Nov.</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>26 November</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Alfred Baer, M.D.</u>				DEGREE				22c. DATE SIGNED 27 Nov, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALFRED BAER, M.D.				22e. ADDRESS 230 24th St. N.W. Washington, D.C. 20037						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/29/1979		23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE CEMETERY		23d. LOCATION HASTINGS ON HUDSON		23e. CITY CHESTER, N.Y.		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.						25a. DATE REC'D. BY REGISTRAR NOV 30 1979		25b. REGISTRAR'S SIGNATURE <u>Barry M. Brady</u>		

BP



## CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MICHAEL B LEVY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 11 1979</b>			2b. HOUR <b>12:40 AM</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 28 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREAT OAKS CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSTITUTIONALISED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>12001 CHERRY HILL ROAD</b>		
14. FATHER'S NAME (DECEASED) FIRST MIDDLE LAST <b>EDWARD S LEVY SR.</b>			15. MOTHER'S MAIDEN NAME (DECEASED) FIRST MIDDLE LAST <b>DAISY BAER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>EDWARD S. LEVY JR. (BROTHER)</b>			ADDRESS <b>806 BRANTFORD AVE SILVER SPRING, MD.</b>								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>5191</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILATERAL PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>TRACHEAL STRICTURE</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>10 DAYS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DOWN'S SYNDROME</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/79</b> to <b>11/13/79</b> , that (I) (we) last saw the deceased alive on <b>11/11/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE <b>R Moyer M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>11/12/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R Moyer M.D.</b>			22e. ADDRESS <b>5606 Chay Chase Pkwy Wash. D.C. 20015</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood PG Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b>			ADDRESS <b>F.H. 11800 N.H. Ave. S.S. Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 2 3 4 5 6 7 8 9 10 11 12

*[Faint handwritten notes at the bottom of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												
1- FOR STATE REGISTRAR					7 9 2 8 4 6 0							
CERTIFICATE OF DEATH					REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	7b. HOUR
Theodore W.					LINDAHL, SR.	Nov.			10-	49		8:30 AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		W. CAUC.		9 06 96		83 YRS.			MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
MINN.		U.S.A.				MONTGOMERY MD.			PAINTING CONTRACTOR			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton			UNIVERSITY NURSING HOME			PAINTING CONTRACTOR						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		901 ARCOLA AVE	
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
1st CHARLES					1st WILHELMINA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS		
YES					ARMY WWI					577-48-0334		
					THEODORE W. LINDAHL, JR.					7202 14th AVE. T.P.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4292										24 hrs		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)												
ASCVD, history of CVA.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22 I certify that (I) (this hospital) attended the deceased from 19 76, to 11-10 19 77, that (we) last saw the deceased alive on 11-9 19 77, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) view the body after death.												
22a. SIGNATURE George H. Langstich, Jr. M.D.										22c. DATE SIGNED 11-10-77		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)										22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		
Burial										Nov 13 1979		
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE		
Cedar Hill Cemetery										Dundalk City Md		
24. FUNERAL DIRECTOR										25. DAY-REC'D BY REGISTRAR		
Victoria Paul House 254 Carroll St. NW										NOV 15 1979		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 6 1

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Georgia Lee Lindsay</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-11-79</b>			2b. HOUR <b>8:30 a.m.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>2 27 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Cafeteria Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert E. Lee</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Dickson</b>			13e. STREET ADDRESS <b>9416 Emory Grove Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>487 10 0893A</b>		17. INFORMANT ADDRESS <b>Same as item 13 a-e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> (c) <b>Generalized Arteriosclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 yrs</b> <b>10 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitis, Megacolon, Bronchopneumonia</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>March 13, 1977</b> to <b>Nov 11, 1979</b> , that (1) (we) last saw the deceased alive on <b>Nov 10, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James R. Moore Jr.</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>Nov 11, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Moore Jr.</b>						22e. ADDRESS <b>207 Brookes Ave Gaithersburg Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kansas City Missouri</b>		
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Pierrey McReady</b>	
23e. ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>									



Robert	E.	Lee	Grace	Dickson
Robert	Montgomery	Gatherburg	2416 Emory Grove Road	
Robert	University	Waring Home	Retired Carter's Manager	
Robert	U.S.A.	XX	Montgomery	
Robert	Lee	2	27 1934	82
Robert	Lee	2	27 1934	82

1931 Rockville Pike Rockville, Md. 20852  
11-1-79 Forest Hill Cemetery Kansas City Missouri  
Theon Heeler Funeral Home, Inc.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Benjamin Sparkman Lowe, Sr.								11/20		11		20		19		79	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	Aug. 13, 1924		55 YRS.						11/20		11		20		1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
N. C.		USA		WIDOWED		DIVORCED		Montgomery County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		2242 Georgian Woods Place		Research Physiologist		Naval											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2242 Georgian Woods Place									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
James Urban Lowe, Sr.						Lottie B. Sparkman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		245-26-7380		Mrs. Curtis H. Lowe/wife/same as 13e													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Acute myocardial disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4029				(b)		hypertensive heart disease.											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		None													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		and in my opinion													
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
John S. Rogers, M.D.		Deputy		11/21/79													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John S. Rogers, M.D.		1919 Seminary Road															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		11-26-79		Beachwood Cemetery		Durham, N. C.											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
John T. Rhines Co.,		3015 12th St., N.E., D. C.				NOV 26 1979		H. J. McCurdy									



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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>HILDA C. LOWES</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>11 12 79</u>		2b. HOUR <u>9<sup>20</sup> P. M.</u>
3. SEX <u>female</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>Nov. 23 1909</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. <del>XXXXXXXXXXXX</del> <del>XXXXXXXXXXXX</del> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.	
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>		13b. COUNTY <u>MONTGOMERY</u>	13c. CITY OR TOWN <u>SILVER SPRING</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>1400 FARMWICK PL.</u>
14. FATHER'S NAME FIRST MIDDLE LAST <del>XXXXXXXXXX</del> <u>W. Collier</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <del>XXXXXXXXXX</del> <u>Clara J. Sterling</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>213-38-3495</u>		17. INFORMANT ADDRESS <u>Rt. 1 Box 4</u> <u>Patricia Wasson-dau-White Plains, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>410-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC CORONARY DS.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONE HOUR</u> <u>SEVERAL YEARS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>HYPOTHYROIDISM</u>					
19a. DATE OF OPERATION <u>N.A.</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N.A.</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. N.A.</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N.A.</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N.A.</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>NA.</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> 19 <u>79</u> , to <u>11/12</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Skinner C. W. M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>11/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Skinner C. W. M.D.</u>		22e. ADDRESS <u>50 W. EDWINSTON DR. ROCKVILLE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11-16-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Sil. Spr. Montgomery Md.</u>		23e. DATE REC'D. BY REGISTRAR <u>NOV 16 1979</u>			
24. FUNERAL DIRECTOR NAME <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Ga. Ave. S.S. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Henry McBratney</u>	

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance and that it has not been completely solved. The author then proceeds to a detailed analysis of the problem, showing that it is a special case of a more general problem. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient.

2. The second part of the paper is devoted to a detailed analysis of the problem. It is shown that the problem is a special case of a more general problem. The author then discusses the various methods that have been used to solve the problem, and shows that the method proposed in this paper is the most efficient.

Chakrabarti



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Flora M. MAC DONALD					2a. DATE OF DEATH November 26, 1979			2b. HOUR 2:45A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH May 10 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Army		12b. KIND OF BUSINESS OR INDUSTRY Nurse Corps			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10504 Montrose Avenue			
14. FATHER'S NAME John W. Mac Donald					15. MOTHER'S MAIDEN NAME Annie Livingston ada						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. (IF YES, GIVE WAR OR DATES) WWII, Korea		17. SOCIAL SECURITY NO. 5 79 52 6979		17. INFORMANT ADDRESS Mr. Kenneth McCrimmon 26 Dayton Crescent Ottawa Ontario Can/					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>large LEFT CEREBRAL STROKE</u> <u>436-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>HYPERTENSION, ARTERIOSCLEROTIC VASCULAR DISEASE</u> (c) <u>DISEASE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 22</u> , 19 <u>79</u> , to <u>Nov. 26</u> , 19 <u>79</u> , that (I) (we) lost <u>saw the deceased alive on Nov. 26</u> , 19 <u>79</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M Vengrow</u>					DEGREE <u>MD</u>		22c. DATE SIGNED Nov. 26, 1979		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M VENGROW</u>					22e. ADDRESS National Naval Medical Center, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 29, 1979		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.				
24. FUNERAL DIRECTOR NAME Robt. A. Pumphrey Funeral Home Bethesda, Md					25a. DATE REC'D. BY REGISTRAR NOV 30 1979					25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>	

1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 4 6 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Robert O Machado</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 21 79</b>		2b. HOUR <b>4 45 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 17 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cuba</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LUIS MACHADO</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTA LUISA ORTEGA</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>577-58-3829</b>		17. INFORMANT <b>WIFE Imelda A. Machado</b> ADDRESS <b>14623 Tynewick Terr. S.S.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brown infarct involving right anterior cerebral artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>artery</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, Arterial Hypertension, Renal Failure, Hypokalemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 6, 1979</b> to <b>Nov. 21, 1979</b> , that (I) (we) lost saw the deceased alive on <b>Nov - 20, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Hugo G. Graziani</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-21-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hugo G. Graziani</b>				22e. ADDRESS <b>800 Pershing Dr. 303A S.S. Md 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>SILVER SP. MD. 500 Unvers. Blvd</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

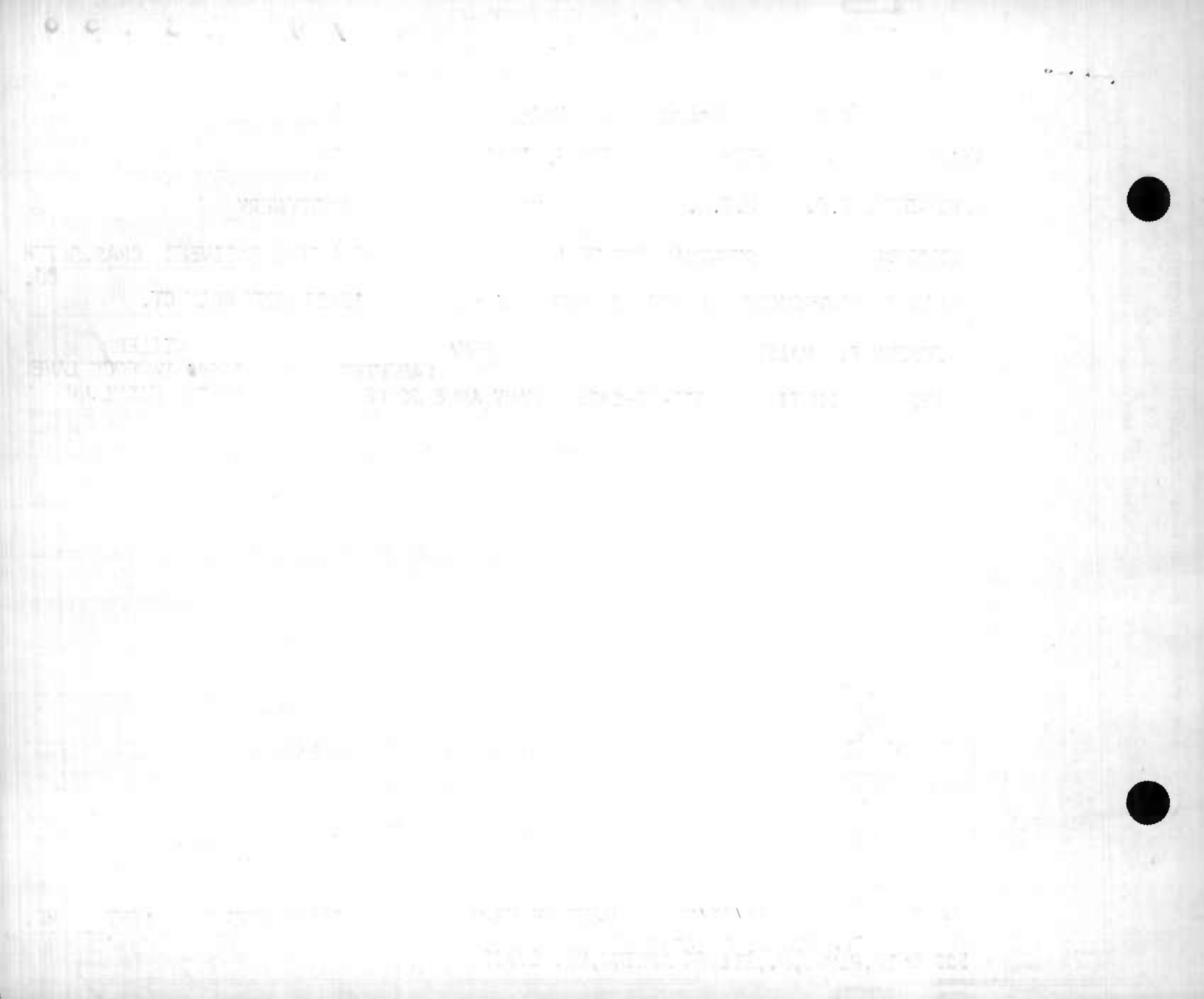


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 4 6 6			
FOR 1 - STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>John Urban Maley</b>				2a DATE OF DEATH MONTH DAY YEAR <b>11/23/79</b>		2b HOUR MIN. <b>10:30 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>FEB 4, 1909</b>		6 AGE (IN YEARS (LAST BIRTHDAY)) YRS. <b>70</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MECHANICAL ENGINEER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>CHAS. SMITH</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b> 13b COUNTY <b>MONTGOMERY</b> 13c CITY OR TOWN <b>SILVER SPRING</b>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>15023 WEST HOLM CT.</b> CO.	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH F. MALEY</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA MILLER</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17 INFORMANT <b>DAUGHTER</b>		ADDRESS <b>1300 PADDOCK LANE BOWIE, MARYLAND</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Sclerosis and Angina</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11/23/79</b> <b>1974</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>5/13/76</b> , 19____, to <b>11/23/79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>10/19/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>John J. Sweeney MD</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11/24/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>John J. Sweeney</b>				22e ADDRESS <b>1905 Gatewood Place</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>11/27/79</b>		23c NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT. MD.</b>	
24 FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b> <b>5000 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b REGISTRAR'S SIGNATURE <b>Mary Keedy</b>	



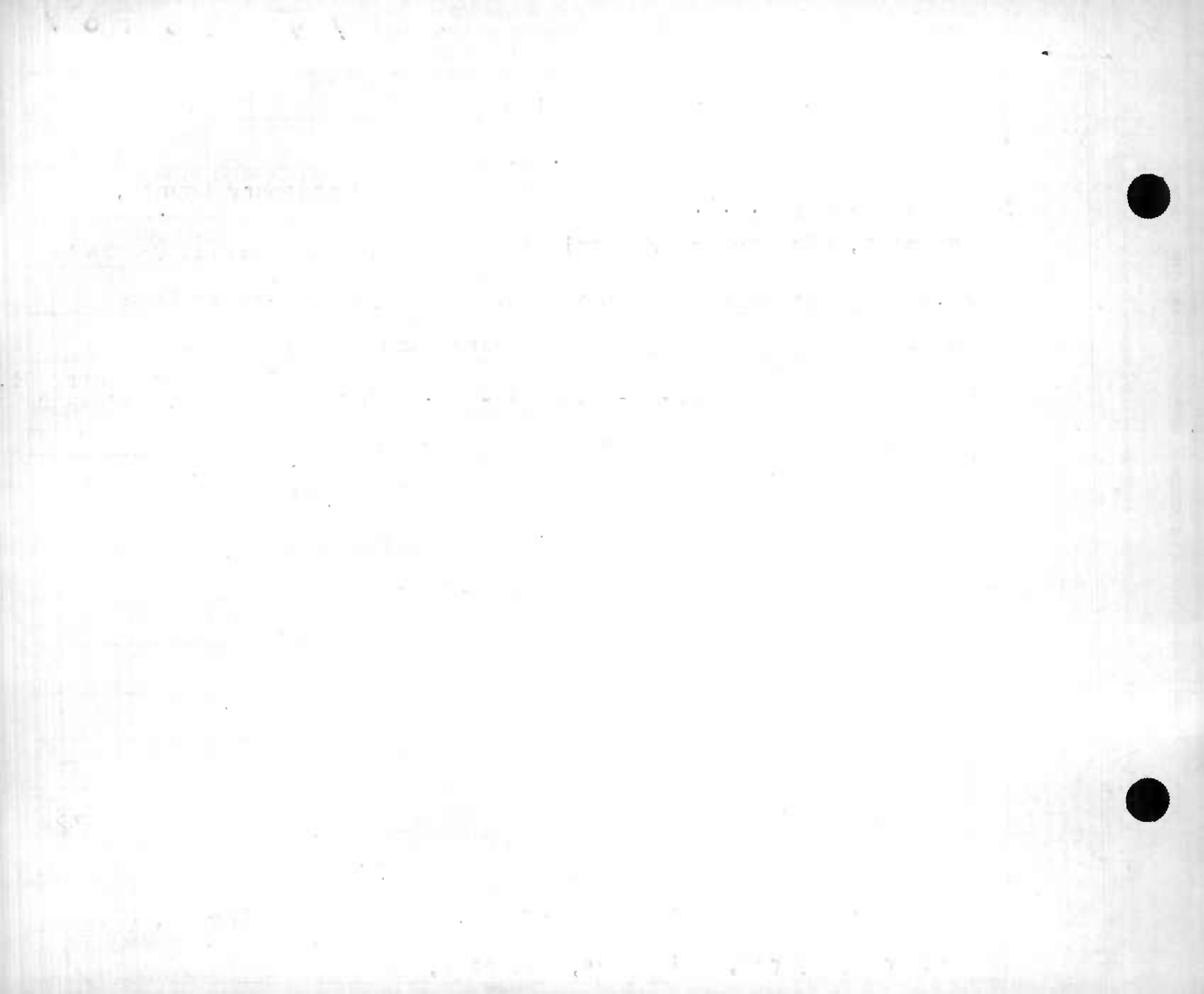
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 6 7	
FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>ANTHONY F. MALIA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 9 79</b>			2b. HOUR <b>1:50 P.M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal Service</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Bethesda</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Malia</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann McAndrew</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>175-01-6228</b>			17. INFORMANT <b>Gerald A. Malia</b>			ADDRESS <b>7616 Winterberry Pl. Bethesda, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Low output cardiac failure</b> <b>4/148</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>OLD myocardial infarct, Atrial Fibrillation</b> (c) <b>Coronary Artery Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Right middle cerebral thromboembolism</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 8</b> 19 <b>76</b> to <b>11-9</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-9</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Roland Imperial MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11-9-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLAND IMPERIAL</b>			22e. ADDRESS <b>4977 BATTERY LANE Bethesda MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

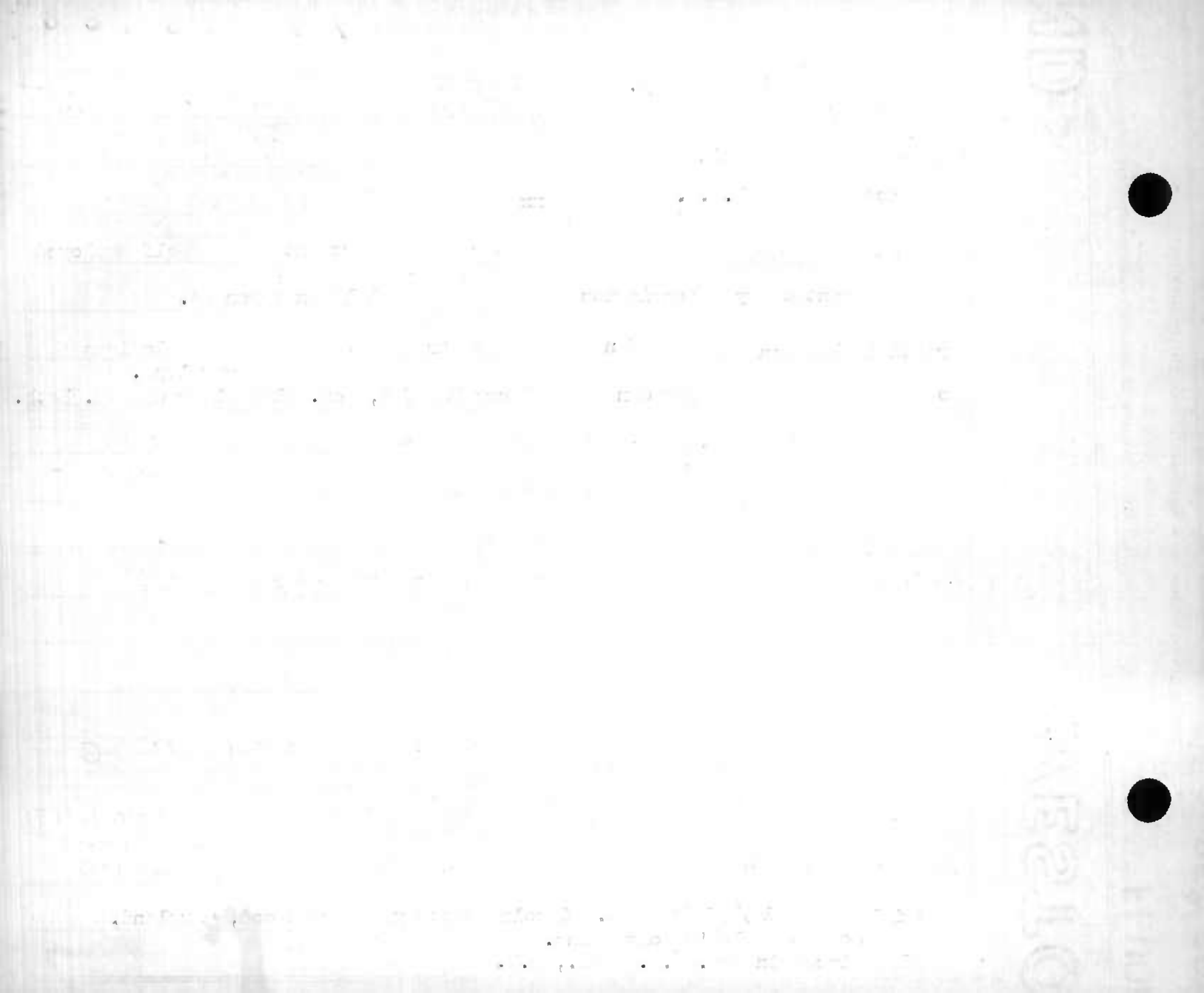




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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Angel A. Magafan</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11-1-79</b>			2b. HOUR <b>7:28 A</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 20 88</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		
13a. STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3512 Anderson Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aristidis Magafan</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Demetra Kolofiras</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>Unknown</b>		17. INFORMANT ADDRESS <b>Maryland.</b> <b>Harry Magafan, Son. 6109 Clearwood Rd. Beth.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGIC SHOCK</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HR</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>GASTRIC VARICES</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNDETERMINED</b>										<b>1 YR. ?</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>DIABETES MELLITUS; CHRONIC LYMPHATIC LEUKEMIA; ARTERIOSCLEROTIC HEART DISEASE</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <b>OCTOBER 23 19 79</b> to <b>NOVEMBER 1 19 79</b> , that (1) (we) lost saw the deceased alive on <b>NOVEMBER 1 19 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John B. Nason, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>Nov. 1, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN B. NASON, M.D.</b>					22e. ADDRESS <b>800 BERTHING DRIVE SILVER SPRING, MD. 20910</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/3/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Maryland.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W. Wash., D.C.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 05 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Long Melbrandy</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR THE 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28469	
1. DECEASED NAME (TYPE OR PRINT) Marry Viola Mann										2a. DATE KNOWN OF DEATH ESTIMATED Nov 25 1979										2b. HOUR 1:00 P.M.	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH May 30, 1892		6. AGE (IN YEARS) (LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Nov 25 1979		2d. HOUR 1:00 P.M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Silver Spg.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Athea Woodland NH.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Home									
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Spr.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1000 Daleview Drive					
14. FATHER'S NAME George				15. MOTHER'S MAIDEN NAME Mary Meier				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 328-44-7822				17. INFORMANT J. David Mann, Jr., Rockville, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vasc Dis.</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH xxx							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION Oct. 15 79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt Hip										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Nov 13 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell in her room													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home Silver Spring, Md				21f. LOCATION STREET Nashville, Illinois				21g. CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER				DATE SIGNED Nov 25 1979									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				1919 Seminary Rd. Silver Spring, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/28/79				23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery				23d. LOCATION CITY OR TOWN Nashville, Illinois									
24. FUNERAL DIRECTOR NAME ROBERT A. BUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR NOV 29 1979																	
25b. REGISTRAR'S SIGNATURE H. J. McCreedy																					



*[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]*



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Barbara Richardson Marmor</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 29, 1979</b>		2b. HOUR <b>5:45<sup>AM</sup></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 6, 1935</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>44 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, (NIH)</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Evangelist</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Hagan Assoc.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>S. Carolina</b>			13b. COUNTY <b>Florence</b>		
13c. CITY OR TOWN <b>Florence</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert W. Richardson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillibell Unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>242-48-2416</b>	17. INFORMANT ADDRESS <b>RT 1 Box 200 Florence, SC 29501</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sepsis, clinical</b> <b>3949</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>valve with Endocarditis of mitral</b> <b>Hemorrhagic pneumonia, bilateral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Malignant lymphoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 9, 1979</b> to <b>Nov. 29, 1979</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Nov. 29, 1979</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <b>Robert M. Lester</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/29/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT M. LESTER</b>		22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md, 20205</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/3/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Florence Nat. Cem</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Florence, South Carolina</b>
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumfrey Funeral Homes, P.A. Bethesda, Maryland</b>		25. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>	
		25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>	

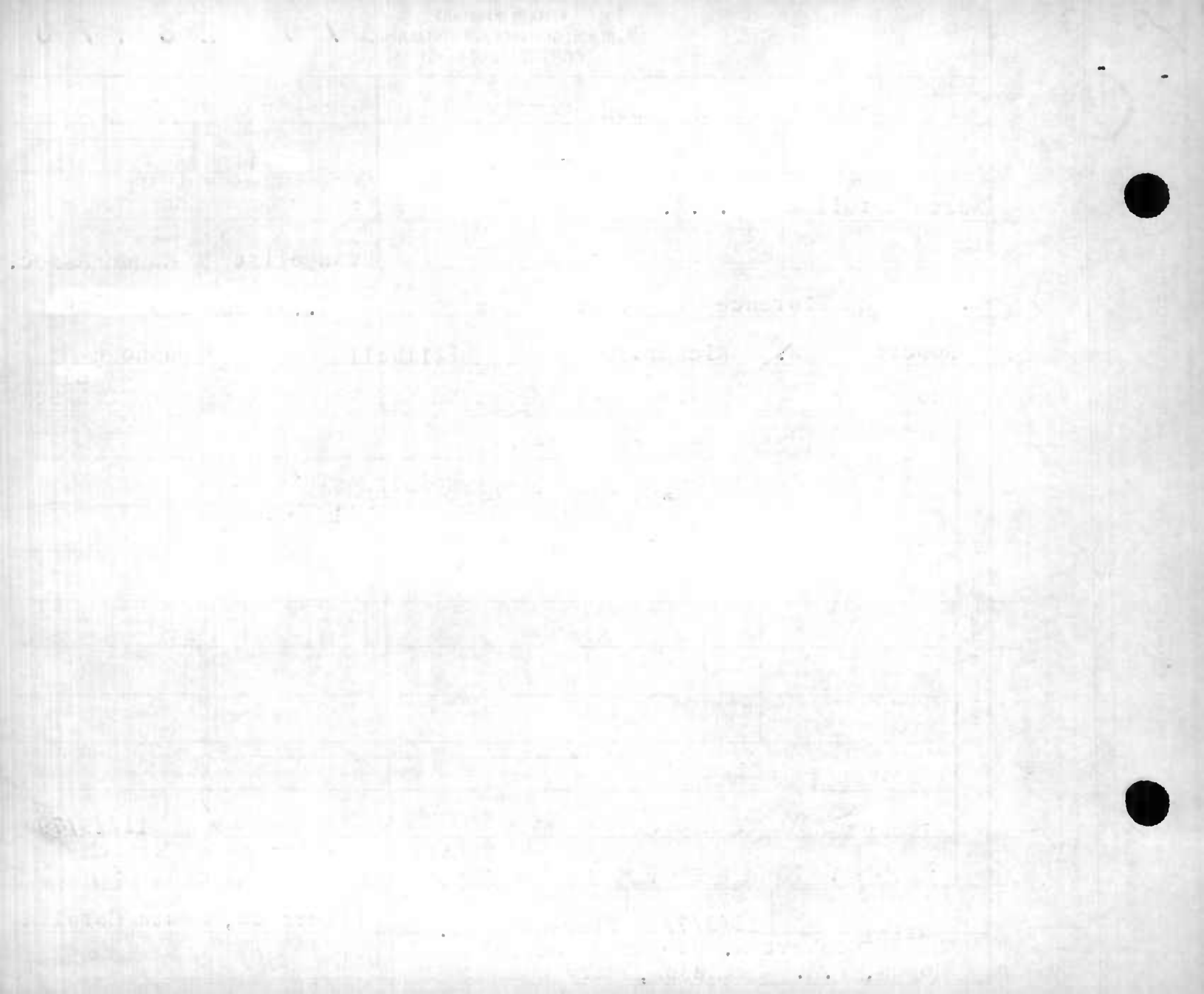
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79 28471 REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James L Martin</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>11/30/79</b>	
3. SEX <b>male</b>	4. RACE <b>blakk</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 16 22</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>57</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>57</b>	IF UNDER 24 HRS. HOURS MIN. <b>57</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11/30/79</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>					
10. CITY OR TOWN OF DEATH <b>22k Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Advent. Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>VA</b>		13b. COUNTY <b>VA</b>		13c. CITY OR TOWN <b>Alexandria</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>610 S. Payne St</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Martin</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Mahaffey</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>MARY L. MARTIN</b>		ADDRESS <b>610 S. Payne St. Alex. Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 yrs.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>[Signature]</b>					TITLE (SPECIFY) <b>MD Dep.</b>			MEDICAL EXAMINER		DATE <b>Nov. 30, 1979</b>	
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Va.</b>				
24. FUNERAL DIRECTOR <b>Greene</b>				ADDRESS <b>814 Franklin St. Alex., Va.</b>				25a. DATE REC'D BY REGISTRAR <b>DEC 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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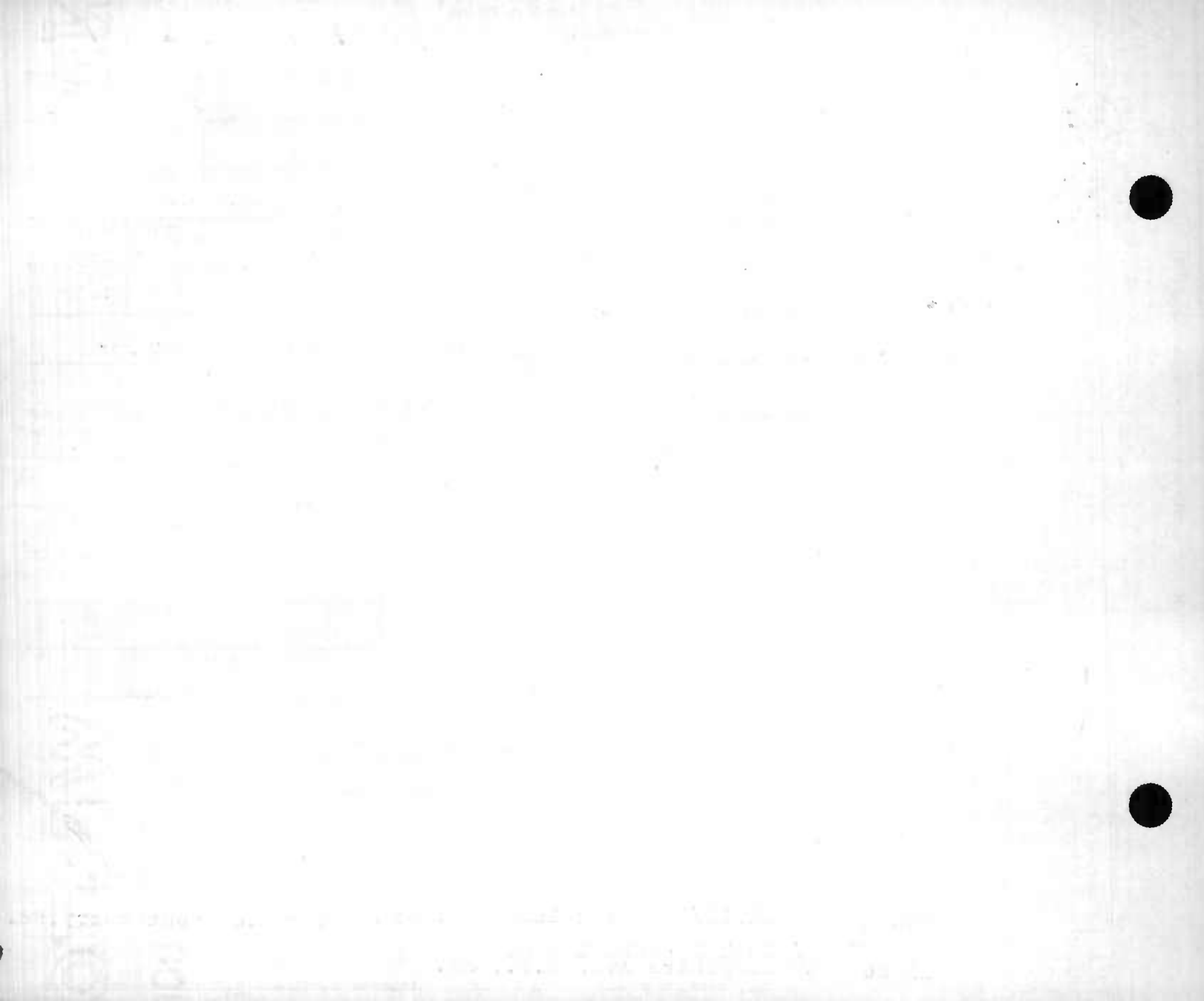
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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 7 2			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Inez</i>		MIDDLE <i>D.</i>		LAST <i>Marsh</i>		2a. DATE OF DEATH		MONTH <i>11</i>	DAY <i>8</i>	YEAR <i>1979</i>	2b. HOUR <i>1:54</i> AM
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH		MONTH <i>12</i>		DAY <i>13</i>		YEAR <i>1924</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Miss.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.							
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Montgomery</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <i>700 Quaint Acres Dr.</i>					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST <i>Grover Cleveland Dickey</i>				FIRST MIDDLE LAST <i>Eva Inez Simmons</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>425-28-9747</i>		17. INFORMANT <i>William Marsh</i>		ADDRESS <i>700 Quaint Acres Drive Silver Spring, Maryland</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i>												<i>minutes</i>	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												<i>days</i>	
DUE TO, OR AS A CONSEQUENCE OF													
(c) <i>myocardial infarction</i>												<i>1 1/2 week</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Acute renal failure</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/29</i> 19 <i>79</i> to <i>11-8</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/8</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Marian Chung</i>				DEGREE <i>M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>11-8-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARIAN CHUNG M.D.</i>				22e. ADDRESS <i>344 University Blvd. W. Silver Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>11/12/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Mem. Park</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Montgomery, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>HINES/RINALDI FUNERAL HOME</i>				ADDRESS <i>11800 New Hampshire Ave. S.S., Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Julia		MIDDLE Matecko		LAST		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11 5 79				2b. HOUR 2 15 M	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Apr. 8, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD Nov. 5 1979 2 15 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Suburban Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Private Club			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 351 Westside Drive			
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown)				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17. INFORMANT Frank Matecko				ADDRESS Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED Nov. 5, 1979					
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS 7936 Old Georgetown Road Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov 9, 1979		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Pittsburgh, Penna.			
24. FUNERAL DIRECTOR NAME Capitol Funeral Service				ADDRESS Fairfax, Va.				25a. DATE REC'D. BY REGISTRAR NOV 13 1979				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

BP



POST OFFICE

PAID



RECEIVED  
JAN 10 1917

X - X

RECEIVED

JAN 10 1917

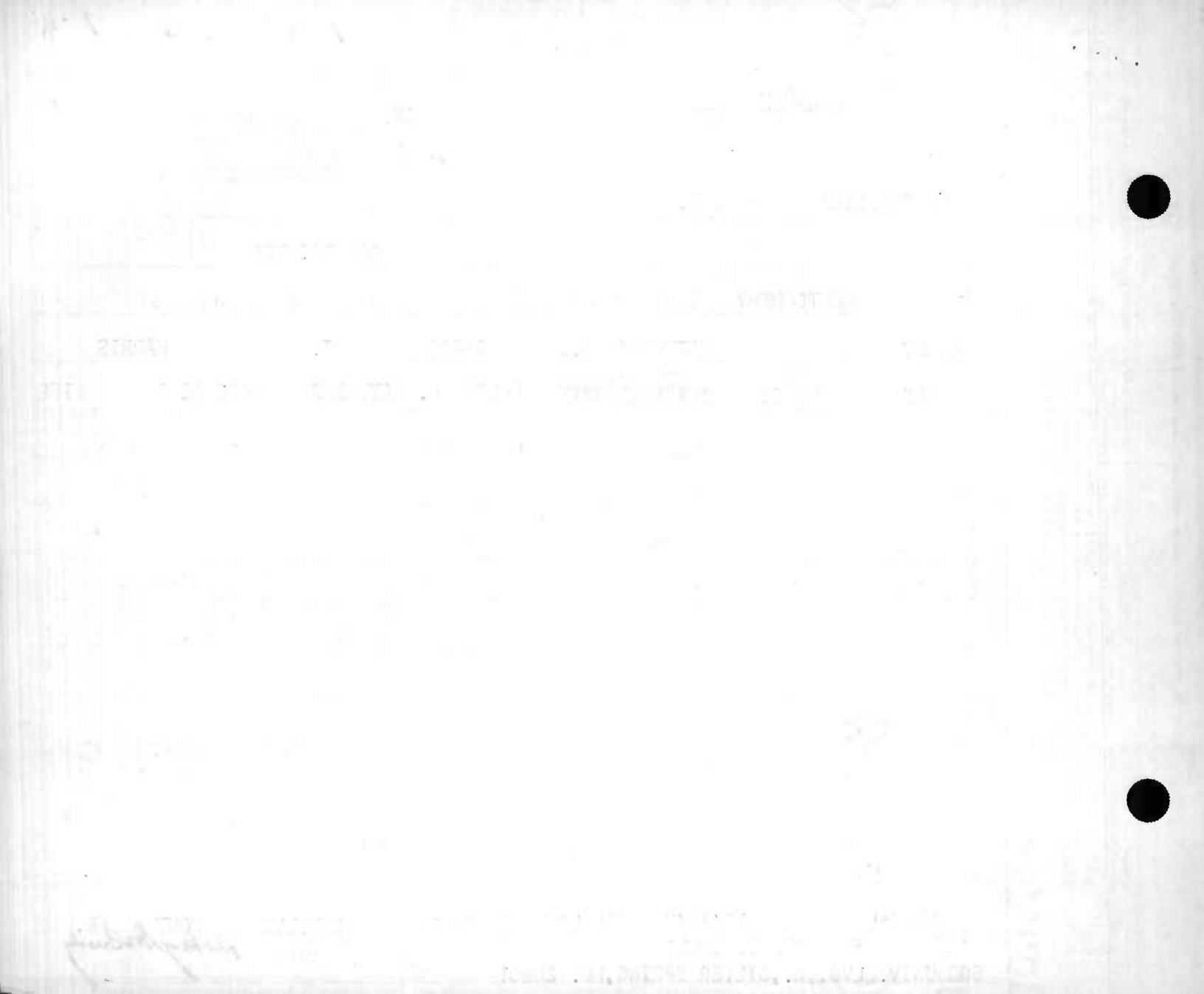


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 7 4		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LeRoy X X X X X Matthews JR					2a. DATE OF DEATH MONTH DAY YEAR 11-27-79				2b. HOUR MIN 12:25 P.M.			
3. SEX MALE					4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 13 1960		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA					7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAR PAINTER		
13a. STATE MD.					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 905 WHITEHALL ST.	
14. FATHER'S NAME FIRST MIDDLE LAST LeROY MATTHEWS, SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE I. HARRIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. 978-07-8882		17. INFORMANT ADDRESS KOLYNA M. MATTHEWS SAME AS 13 WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 5715 DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) LIVER Cirrhosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hr 6 Mo 2 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CARCINOMA - Testicle (left); Diabetes Mellitus												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 5, 1976, to 11/27, 1979, that (I) (we) lost saw the deceased alive on 11/27/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Helen Kay M.D.								22c. DATE SIGNED 11/27/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) HELEN KAY M.D.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 11/30/79		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.		23e. DATE REC'D BY REGISTRAR DEC 3 1979		
24. FUNERAL DIRECTOR NAME F RANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901												



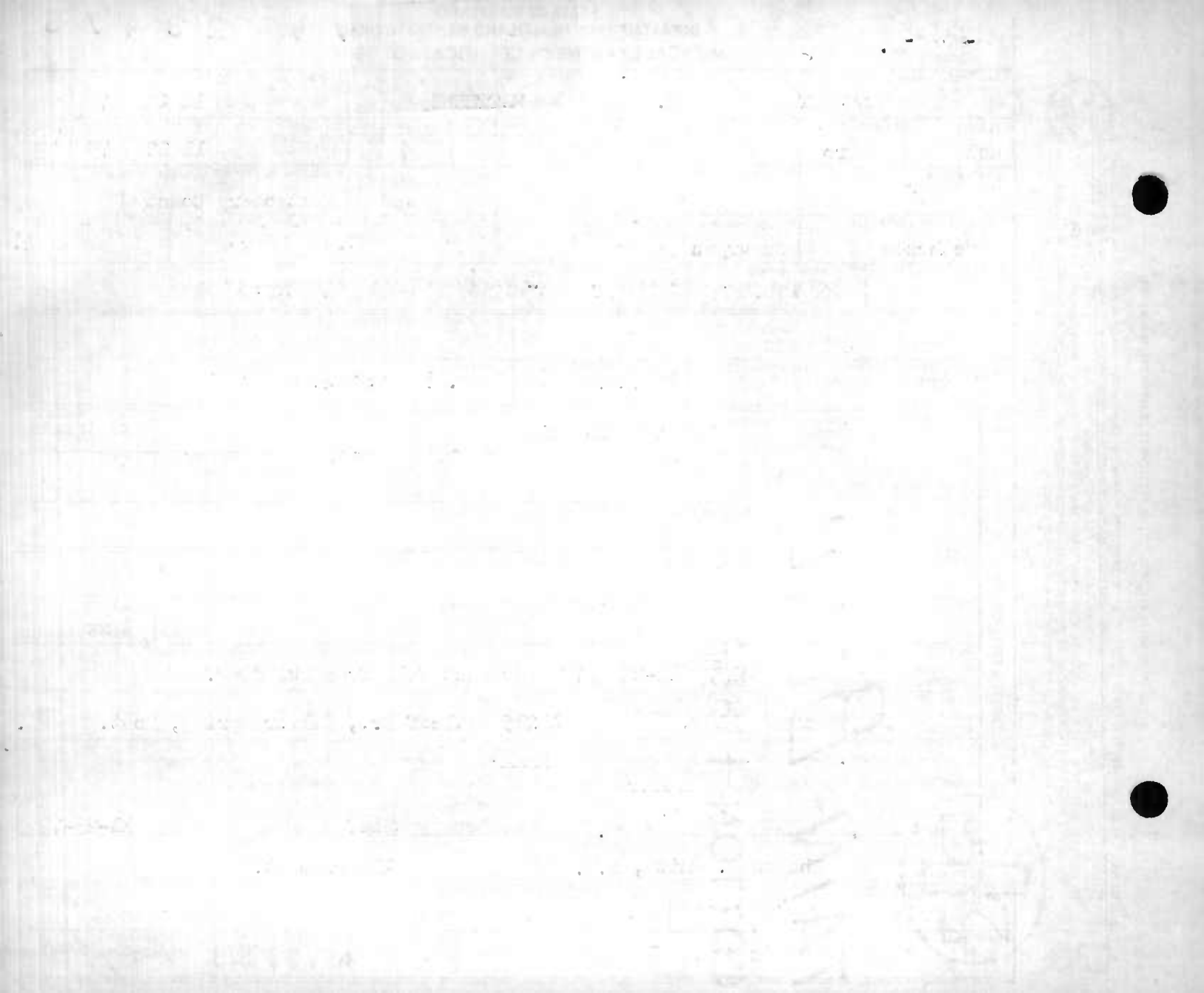


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR 15 ME (5))  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT M. MATTHEWS						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 11 22 1979		2b. HOUR M	
3. SEX male		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 5 22 1955		6. AGE (IN YEARS LAST BIRTHDAY) 24 RS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 22 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1611 April Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Matthews						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Washington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Frank Matthews - SAA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple injuries IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b): DUE TO, OR AS A CONSEQUENCE OF (c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR:MIN MONTH DAY YEAR 6:15 P.M. 11-22-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject fell from building.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bldg.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11215 Oakleaf Dr., Silver Spring, Mont. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 11-23-79			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/29/1979		23c. NAME OF CEMETERY OR CREMATORY Good Hope Church				23d. LOCATION CITY OR TOWN COUNTY STATE Good Hope, Maryland			
24. FUNERAL DIRECTOR NAME W. Ernest Jarvis Co., Inc. 1432 You St., NW						25a. DATE REC'D. BY REGISTRAR NOV 30 1979		25b. REGISTRAR'S SIGNATURE <i>Barney McBr...</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 7 6	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
EDNA RUTH MAURER			NOVEMBER 14 1979			0915			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		CAUCASIAN		DEC 7 1913		65		MONTHS DAYS		HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITIZEN OF WHAT COUNTRY?			11. BALTIMORE CITY OR COUNTY OF DEATH			12. MD.		
PENNSYLVANIA			USA			MONTGOMERY COUNTY					
13. CITY OR TOWN OF DEATH			14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			NATIONAL NAVAL MEDICAL CENTER			Housewife			Home		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. CITY OR TOWN			19. INSIDE CITY LIMITS?			20. STREET ADDRESS		
17a. STATE			17b. COUNTY			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			406A COUNTRY DRIVE		
DELAWARE			KENT			DOVER					
21. FATHER'S NAME			22. MOTHER'S MAIDEN NAME			23. ADDRESS					
William S. Gardner			Anna C. Moore			406A COUNTRY DR					
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			25. SOCIAL SECURITY NO			26. INFORMANT			27. ADDRESS		
YES			148-09-5428			JOANNE M. MAURER (DAUGHTER)			406A COUNTRY DR		
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>sepsis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
29a. DATE OF OPERATION			29b. CONDITION FOR WHICH OPERATION WAS PERFORMED			30a. AUTOPSY?			30b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
31a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			31b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			31c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
32a. INJURY OCCURRED			32b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			32c. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						CITY OR TOWN			COUNTY STATE		
33. I certify that (I) (this hospital) attended the deceased from <u>31 October 1979</u> to <u>14 Nov. 1979</u> , that (I) (we) lost saw the deceased expire on <u>14 Nov. 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
34. SIGNATURE						DEGREE			35. DATE SIGNED		
COLVIN, D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			14 Nov 79		
36. PHYSICIAN'S NAME (TYPE OR PRINT)						37. ADDRESS					
COLVIN, D.						NNMC Bethesda, Maryland					
38. BURIAL, CREMATION, REMOVAL (SPECIFY)			39. DATE			40. NAME OF CEMETERY OR CREMATORY			41. LOCATION		
Burial			11/17/79			Arlington Cemetery			Pennsauken, New Jersey		
42. FUNERAL DIRECTOR NAME						43. DATE REC'D. BY REGISTRAR			44. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						NOV 19 1979			[Signature]		



Home

Housewife

Moore

C.

Anna

Gardner

S.

William

1 - - 3

XV

Robert A. Gardner  
William S. Gardner  
Anna C. Gardner  
Moore C.  
Home

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												7 9 2 8 4 7 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Jewel Anne Mzyberry												2a. DATE KNOWN OF DEATH ESTI- MATED Nov. 11 19 79												2b. HOUR 4:28 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR June 5 45			6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Nov. 12 19 79				2d. HOUR 3:40 M										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD															
10. CITY OR TOWN OF DEATH Burtonsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4100 Sandy Spring Rd								12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Nursing Assistant				12b. KIND OF BUSINESS OR INDUSTRY Hospital											
13a. STATE MD				13b. COUNTY Mont				13c. CITY OR TOWN Burtonsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4100 Sandy Spring Rd.													
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR L. HUME				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED STRAUB																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.				17. INFORMANT JAMES H. MAYBERRY - 4100 SANDY SPR. RD								ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9537 IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 11 19 79 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot in mouth with Shotgun.																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Sandy Spring Rd. Burtonsville Mont. MD																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE John Rogers				TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER				DATE SIGNED Nov. 12 1979																			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov. 14, 1979				23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen P.D. MD															
24. FUNERAL DIRECTOR NAME Takoma Funeral Home				ADDRESS 2500 Connell St NW				25a. DATE RECD. BY REGISTRAR NOV 15 1979				25b. REGISTRAR'S SIGNATURE Ruth M. Mzyberry															



From June 1st to July 1st 1911  
June 1st to July 1st 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 7 8			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Margaret		L.		McAlwee				November		9	1979	11	P.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7a. IN YEARS (LAST BIRTHDAY)		7b. IF UNDER 1 YEAR		7c. IF UNDER 2 HRS	
female		white		Sept 20, 1903		76		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
WASHINGTON, D. C.		U.S.A.				MONTGOMERY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
WHEATON		RANDOLPH HILLS NURSING HOME		ADMINISTRATIVE ASST.		RFC							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15121 GLADE DRIVE					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
OLLIE		LEAMAN		MARY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		578-54-6868		BENJAMIN V. McALWEE		SAME AS 13 HUSBAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer - Respiratory Tract</u> 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Septicemia</u> (c) <u>Due to, or as a consequence of</u> 48 Hours		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Atherosclerotic Cardiovascular Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from <u>August 24, 1978</u> to <u>November 9, 1978</u> , that (2) (we) lost <u>about 10 days</u> (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Benjamin Aronow, M.D.</u> DEGREE		22c. DATE SIGNED <u>11-10-78</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Benjamin Aronow, M.D.		3720 Fannusut Ave. Kensington, Md. 20755											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		11/13/79		CEDAR HILL CEMETERY		SUITLAND							
24. FUNERAL DIRECTOR'S NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE							
FRANCIS J. COLLINS				NOV 15 1979		<u>[Signature]</u>							
100 UNIV. BLVD., W., SILVER SPRING, MD. 20901													





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. 9		2. 8		4. 7		9	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KIMBERLY ANN MC CORMICK				2a. DATE OF DEATH MONTH DAY YEAR 17 NOV 79				2b. HOUR 0700 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 9, 1974		6. AGE (IN YEARS LAST BIRTHDAY) 04		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County XX			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION National Naval Medical Ctr.				12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE VIRGINIA				13b. COUNTY PRINCE WILLIAM		13c. CITY OR TOWN QUANTICO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RAY MELTON MC CORMICK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINDA GAIL STANLEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO none		17. INFORMANT ADDRESS RAY M. AND LINDA G. MC CORMICK SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). LEUKEMIA 2089 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-11-79 to 11-17-79, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 8-14-79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE John R. Steenbarger				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 17NOV79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. STEENBARGER				22e. ADDRESS NATNAVMEDCEN, BETHESDA, MD 20014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/21/79		23c. NAME OF CEMETERY OR CREMATORY Main Post Cemetery		23d. LOCATION Ft. Benning, Georgia		23e. STATE Georgia	
24. FUNERAL DIRECTOR NAME ROBERT PUMPHREY, BETHESDA, MD				25r. DATE RECEIVED BY REGISTRAR NOV 26 1979		25b. REGISTRAR'S SIGNATURE			

1918

RECEIVED

NOV 10 1918

By S. M. ...

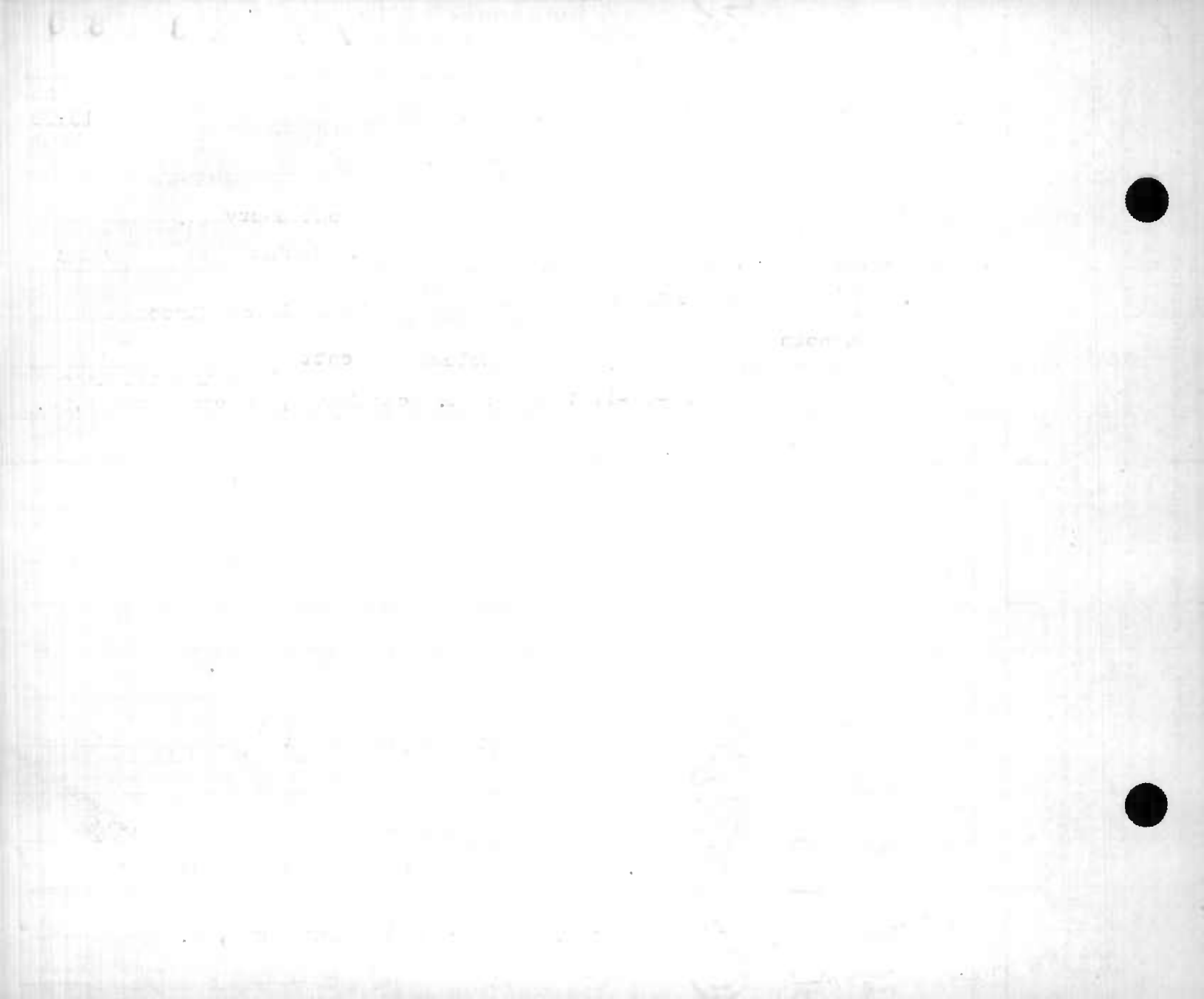
1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 8 4 8 0																													
FOR 1- STATE REGISTRAR					REG. NO.																																		
1. DECEASED NAME (TYPE OR PRINT)					FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		am																		
Ethel					H		McCullough				11		30		79		10:00																						
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)					7. IF UNDER 1 YEAR					8. IF UNDER 24 HRS														
F					B					10 07 06					73					MONTHS					DAYS					HOURS					MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					9. BALTIMORE CITY OR COUNTY OF DEATH					10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY									
VA					US					MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					Montgomery					SILVER SPRING					HOLY CROSS HOSPITAL					HOUSEWIFE					NONE				
13a. STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS																			
VA.					ALEXANDRIA					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					1213 Gibbon Street																								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS														
Unknown					Helena Scott					No					230-30-7797					James C. McCullough					1801 Crystal Lane Silver Springs, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) Myocardial Infarction																																							
410- DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																							
(b) Coronary Artery Disease																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																								
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that (I) (this hospital) attended the deceased from 10-29, 19-79, to 11-30, 19-79, that (I) (we) lost saw the deceased alive on 11-30, 19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE										DEGREE										22c. DATE SIGNED																			
Steven A. Burger, MD										MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										12-1-79																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																													
Steven A. Burger, MD										10301 Georgia Ave. Silver Spring, Md																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE																								
BURIAL					12/4/79					Alexandria National					Alexandria, Va																								
24. FUNERAL DIRECTOR NAME										24b. ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Nelson E. Greene, Jr.										814 FARMHILL ST Alex. VA 22314										DEC 6 1979		Rickey McCready																	



TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1- FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
ARTHUR E. McNUTT			11		- 15 -		79		5-10		P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
m		White		Dec. 18, 1943		35		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
New York		U.S.A.				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR					
Silver Spring		Holy Cross Hospital				Aero Space Techn.		Goddard Space Center					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE Md.										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9608 48th Pl.	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME			
Walter K. McNutt										Emma Garlough			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No										348-38-8459		Janet McNutt Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage													
430- DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
none		none				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED									
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from										22c. DATE SIGNED			
Nov. 5, 1979, to Nov. 15, 1979, that (I) (we) lost													
22b. SIGNATURE										22c. DATE SIGNED			
Charles L. Franklin Jr.										11-15-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS			
Charles L. Franklin Jr.										11200 Lockwood Dr Silver Spring Md 20901			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE					
Cremation		11-17-79		Ft. Lincoln Crematory		Brentwood, P.G. Md.		NOV 19 1979					
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR			
F. Gasch's Sons, P.A., Hyattsville, Md.										NOV 19 1979			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Maria		E				Merlos		11		1		19		79		2:33 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
F	W	4 6 28		50 YRS.						11		1		19		79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
El Salvador		El Salvador				Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda		Suburban				Dish Washer											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
D. C.				Washington				3624 Conn Ave., N. W. #43									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST					
Lazaro Umana						Mercedes Merlos											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		Not Stated		Bertha L. Tessier, 1811 Vernon St., N.W.		Wash., D.C. #22											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Coronary Insufficiency Acute		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
411-		DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		John G. Ball		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED		Nov 1, 1979							
EXAMINER'S NAME (TYPE OR PRINT)		John G. Ball		ADDRESS		7936 Georgetown Rd., Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Removal		5 Nov 79		Ship to		San Salvador, El Salvador											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
W. Ernest Jarvis Co., Inc.		1432 You St., N. W. Washington, D. C.		NOV 2 1979													



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ON ST., BALTIMORE, MARYLAND 21201

death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the attending physician and completely filled in by the funeral director, page 3 carbon papers. Pages 1 and 2 should be filed within 72 hours after death in, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 8 3

FOR  
1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>JUSTINE HARKINS MERRILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-27-79</b>		2b. HOUR <b>12:45 AM</b>
3 SEX <b>Female</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>May 27, 1923</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	7a. IF UNDER 1 YEAR MONTHS DAYS <b>11</b> MONTHS <b>27</b> DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>	7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD		
10 CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SURBURBAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>			13c. CITY OR TOWN <b>Montgomery</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lloyd Lincoln Harkins</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gladys Leola Nichols</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO <b>578-32-8239</b>		17 INFORMANT <b>Husband--</b> ADDRESS <b>Lawrence L. Merrill--(see item 13)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <b>14 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Renal Failure</b>					
19a. DATE OF OPERATION <b>26 Nov 79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetes Mellitus</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from <b>13 Nov 79</b> to <b>26 Nov 79</b> , that (ii) (we) last saw the deceased alive on <b>26 Nov 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) did (and) not view the body after death.					
22b. SIGNATURE <b>Paul Noone</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-27-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Noone, M.D.</b>		22e. ADDRESS <b>Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Culpeper National</b>	
24 FUNERAL DIRECTOR NAME <b>Colonial Funeral Home</b>		ADDRESS <b>6161 Leesburg Pike</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Culpeper Virginia</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be contacted once again.

BP\_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 4 8 4	
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH			3. HOUR		4. REG. NO.			
EDWARD A. Miller			NOVEMBER 14 1979		0640 M						
5. SEX		6. RACE		7. DATE OF BIRTH		8. AGE (IN YEARS LAST BIRTHDAY)		9. IF UNDER 1 YEAR		10. IF UNDER 24 HRS	
MALE		CAUCASIAN		APRIL 16 1929		50		MONTHS		DAYS	
						YRS. 6		HOURS		MIN.	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			12. CITIZEN OF WHAT COUNTRY?			13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			14. BALTIMORE CITY OR COUNTY OF DEATH		
ALABAMA			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTGOMERY COUNTY MD.		
15. CITY OR TOWN OF DEATH			16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			17. USUAL OCCUPATION			18. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			NATIONAL NAVAL MEDICAL CENTER			ELECTRONICS			U.S. Army		
19. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			20. INSIDE CITY LIMITS?			21. STREET ADDRESS			22. ZIP CODE		
13a. STATE N.J.			13b. COUNTY MONMOUTH			13c. CITY OR TOWN NEPTUNE			13d. STREET ADDRESS 8 ASH DRIVE		
13e. ZIP CODE 07753			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS		
JAMES MILLER, JR.			Corrine SEALEY			ANN MARIE MILLER 8 ASH DR. NEPTUNE, N.J.			07753		
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18. SOCIAL SECURITY NO			19. INFORMANT			20. ADDRESS		
YES			WWII			419-26-9 294			ANN MARIE MILLER 8 ASH DR. NEPTUNE, N.J. 07753		
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CEREBRAL EDEMA											
2000 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
(c) ACUTE HISTIOCYTIC LYMPHOMA (Diffuse Type)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
23. DATE OF OPERATION			24. CONDITION FOR WHICH OPERATION WAS PERFORMED			25. AUTOPSY?			26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			28. TIME OF INJURY			29. HOW INJURY OCCURRED			30. (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
31. INJURY OCCURRED			32. PLACE OF INJURY			33. LOCATION			34. STATE		
AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN			COUNTY		
35. I certify that (this hospital) attended the deceased from 2 Nov. 1979, to 14 Nov. 1979, that (I) (we) lost saw the deceased alive on 14 Nov. 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
36. SIGNATURE						37. DEGREE			38. DATE SIGNED		
Jeffrey M. Crane						MD			4 Nov 79		
39. PHYSICIAN'S NAME (TYPE OR PRINT)						40. ADDRESS					
JEFFREY M. CRANE						NNMC, BETHESDA, MD. 20014					
41. BURIAL, CREMATION, REMOVAL (SPECIFY)			42. DATE			43. NAME OF CEMETERY OR CREMATORY			44. LOCATION		
Burial			11/17/79			Monmouth Mem Park			Tinton Falls, New Jersey		
45. FUNERAL DIRECTOR						46. DATE REC'D. BY REGISTRAR			47. REGISTRAR'S SIGNATURE		
Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland						NOV 19 1979			[Signature]		



Released by Dr. Mayle

DHMH-16 25M  
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL R. MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 20 79</b>				2b. HOUR <b>12:30</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 17, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CO. MD.</b>				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Justice Dept.</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4708 Bradley Blvd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin C. Struhs</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Kidwell</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				
16a. SOCIAL SECURITY NO. <b>215-36-4375</b>			17. INFORMANT ADDRESS <b>10643 Montrose Av.</b> <b>Catherine M. Bailey Bethesda, MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> (c) <b>Coronary artery disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>10:30 AM</b>		CITY OR TOWN <b>1230</b>		COUNTY <b>STATE</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>11-20-79</b> , 19 <b>79</b> , to <b>11-20-79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11-20-79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>H. Bahar</b>			DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11-20-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HADI BAHAR</b>			22e. ADDRESS <b>8218 Wisconsin Ave BETHESDA MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crem.</b>			23d. LOCATION CITY OR TOWN <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>					

MEDICAL CERTIFICATION



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

7 9 2 8 4 8 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lillian Mae Montgomery</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>15</b> YEAR <b>79</b>		2b. HOUR <b>4<sup>15</sup></b> A M						
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>12</b> YEAR <b>1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 years</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>D. C.</b>						13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Murray</b> LAST <b></b>						15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Crutcher</b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>417-18-0780D</b>		17. INFORMANT ADDRESS <b>Washington, D. C.</b> <b>Eunice Alexander, Daughter, 610 E St., N.E.</b>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Renal Failure</b> (c) <b>Diabetes Mellitus</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11-10-79</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASCVD, Multiple CVA, Ischemic Heart Disease</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>				21b. TIME OF INJURY HOUR A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>			
22a. I certify that (1) this hospital attended the deceased from <b>11-6-79</b> , 19 <b></b> , to <b>11-15-79</b> , 19 <b></b> , that (1) <b>we</b> lost saw the deceased alive on <b>11-14-79</b> , 19 <b></b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (1) <b>we</b> (did not) view the body after death.											
22b. SIGNATURE <b>MB Patrule III MD</b>								DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-15-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G B Patrule III MD</b>								22e. ADDRESS <b>9221 Colesville Rd Silver Spring, Md 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>20 Nov 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION CITY OR TOWN <b>Suitland, P. G. Co. Maryland</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>W. Ernest Jarvis Co., Inc., 1432 You St., N.W.</b>				ADDRESS <b>Washington, D.C.</b>				25. DATE OF DEATH BY OTHER PARTY <b>NOV 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b></b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 8 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Edith Austin Moore		Nov. 21, 1979		7:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	97 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	U.S.A.		Montgomery County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rockville	Collingswood Nursing Home		Homemaker		Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Silver Spring	<input type="checkbox"/> YES <input type="checkbox"/> NO	1216 Tanley Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Daniel Austin		Minnie Cheesbro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		264-80-1397		John H. Austin, Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure					None
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Antihypertensive Heart disease					year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 11/13/79 to 11/21/79, that (I) (we) last saw the deceased alive on 11/13/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thos G. WARD, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Thos G. WARD		6116 Robinwood, Bethesda, Md 20034			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Nov. 26, 1979		Village of Mexico Mexico, New York	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Robert A. Pumphrey Funeral Homes, P.A.		Rockville, Md.		NOV 29 1979	
				25b. REGISTRAR'S SIGNATURE	
				Dorothy McBrady	

MEDICAL CERTIFICATION

29

1

1503 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		3. SEX				4. RACE			
CLARENCE		MALE				BLACK			
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. BALTIMORE CITY OR COUNTY OF DEATH			
MORGAN JR		45				MONTGOMERY			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?				10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
TEXAS		UNITED STATES				NATIONAL NAVAL MEDICAL CENTER			
11. CITY OR TOWN OF DEATH		12. USUAL OCCUPATION				13. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		U.S. NAVY				YNC			
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?				16. STREET ADDRESS			
13a. STATE		13b. COUNTY				13c. CITY OR TOWN			
CALIFORNIA		LOS ANGELES				LOS ANGELES			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME				16. INFORMANT			
CLARENCE		CLARICE				MAJORS			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18. SOCIAL SECURITY NO				19. ADDRESS			
YES		466-50-3789				QUEEN ESTHER MORGAN SAA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1: DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ACUTE EXTENSION OF RECENT MYOCARDIAL INFARCTION									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 31 OCT 19 79 to 01 NOV 19 79, that (we) lost									
saw the deceased alive on 01 NOV 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
MICHAEL DURAN LT MC		02 NOV 79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
		NATIONAL NAVAL MEDICAL CENTER							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE	
Burial		11-7-79		Ridge Park		Hillsboro, Hill, Texas			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
W. W. Chambers Co.,		Silver Spring, Md.		NOV 14 1979					

59-28488



*McGraw-Hill*

11-7-78 Ridge Park Hillboro, Ill., Texas

NOV 14 1978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
James Blanchard MORRISON						November 5 1979			525A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male	Caucasian	May 27 1920		59 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
North Carolina	USA			Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	National Naval Medical Center			Teacher			P. G. Co. Schools		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? EYES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS					
Maryland	Pr. George	Mitchellville		2701 Enterprise Road					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS					
Yes			WWII	245 60 9650		Mrs. Evelyn Morrison See item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2051									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Blast Crisis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic myelogenous leukemia</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Thrombocytopenia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 25</u> , 19 <u>79</u> , to <u>Nov. 5</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 5</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. J. Chobanian</u> M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED Nov. 5, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. J. Chobanian, M.D.</u>				22e. ADDRESS <u>National Naval Medical Center, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>9 NOV 79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Alexandria, Virginia</u>			
24. FUNERAL DIRECTOR NAME <u>Beall Funeral Home</u>				ADDRESS <u>W. Sullivan Lanham, Maryland</u>		25a. DATE REC'D BY REGISTRAR <u>NOV 08 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1 2 3 4 5 6



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR 15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										9 28490	
1- STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH DAY YEAR	
Robert Lee Moser								Nov 28 1979		10 25 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD	
M	W	Oct 14 29		50 YRS.						Nov 28 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.		WIDOWED		DIVORCED		Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery General Hosp		Carpenter		None					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		13701 Catoclin Furnace Road			
MD		Frederick		Thurmont		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD-3			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Unknown		Ruth Moser									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		13701 Catoclin Furnace Rd. Thurmont, Md.			
?		214-28-0018		Mrs. Margaret L. Moser							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Acute Myocardial Dis											
4291											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
John Rogers, M.D.		M.D. Dep.		MEDICAL EXAMINER		Nov 28 1979					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
John Rogers, M.D.		Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		12-1-1979		Mt. Bethel Cemetery		Foxville, Frederick, Maryland					
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
DEC 6 1979		Robert E. Dailey & Son		ADDRESS 615 East Main Street		Thurmont, Md. 21788					

*[Faint, illegible handwriting on lined paper]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 8 4 9 1	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MURIE M. Mulvey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 02 79</b>		2b. HOUR <b>8:30 A.M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 11, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POST OFFICE ADMINISTRATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>PRINCE GEO.</b>	13c. CITY OR TOWN <b>ADELPHI</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LAFAYETTE MOODY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY LONGENBECH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-52-8203</b>		17. INFORMANT ADDRESS <b>SISTER 21 S 2ND STREET ESTHER GROSE LEBANON, PA.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a) and (b). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic breast CA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 78</b> , 19____, to <b>Nov 2, 79</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/1/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. Smith</b>		DEGREE		22c. DATE SIGNED <b>11/2/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Smith Ho MD</b>		22e. ADDRESS <b>8323 Haddon Dr. Takoma PK md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER CEMETERY</b>	
				23d. LOCATION CITY OR TOWN COUNTY STATE <b>LEBANON LEBANON PA</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 8 1979</b>		
25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>					

BP

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LEBANON, PA.	51 S 2ND STREET	LONGMEAD	2300 ALABAMA STREET	POST OFFICE ADMINISTRATOR	MONTGOMERY	78
LEBANON, PA.	51 S 2ND STREET	LONGMEAD	2300 ALABAMA STREET	POST OFFICE ADMINISTRATOR	MONTGOMERY	78
LEBANON, PA.	51 S 2ND STREET	LONGMEAD	2300 ALABAMA STREET	POST OFFICE ADMINISTRATOR	MONTGOMERY	78

500 INDIAN BLVD. SILVER SPRING, MD. 20906  
FRANCIS J. COLLINS  
11/1/79  
FEBRUARY 1979  
LEBANON, PA.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Richard J. Muniot		11.6.1979		7:05 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
male	white	8-20-1927	52 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Louisiana	U.S.	NEVER MARRIED		Montgomery MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda	Suburban Hospital	restaurateur			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	11419 Commonwealth Drive	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
Joseph E. Muniot	Emma Matthew	437-50-6917			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT			
yes	W.W. 11	Nancy R. Muniot			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John G. Ball		M.D. Deputy		Nov 6, 1979	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
John G. Ball, M.D.		7936 Old Georgetown Rd. Beth. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
cremation	11-8-1979	Delmarva Crematory		Lewes, Sussex, Delaware	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		NOV 9 1979			
Newnam Funeral Home		Easton, Md.			





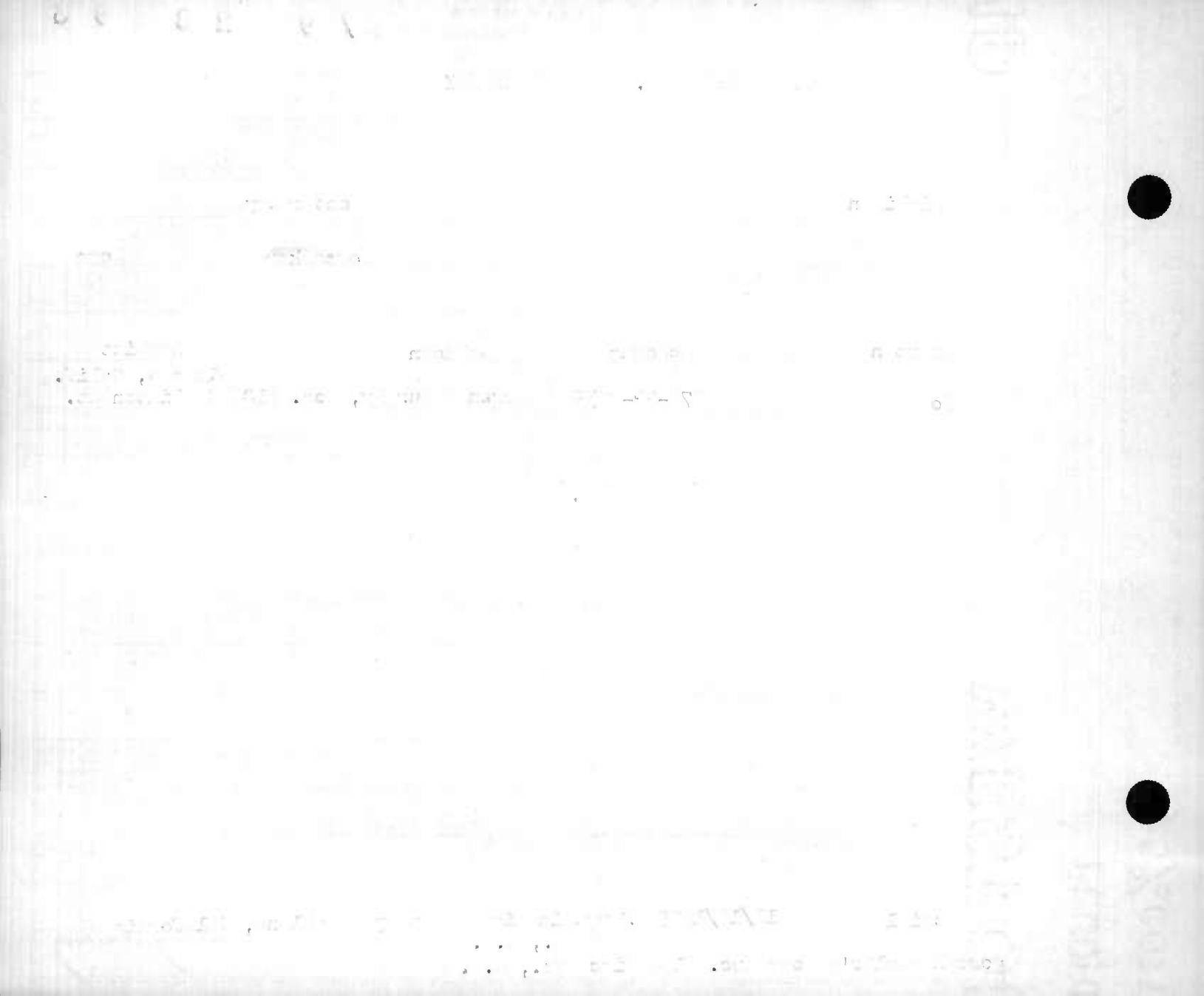
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 4 9 3	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH P. MURPHY			2a. DATE OF DEATH MONTH DAY YEAR 11-8-79		2b. HOUR 10 17 A
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8-30-1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? USA	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN BETHESDA		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Nesbitt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-72-0835		17. INFORMANT ADDRESS Alameda, Calif. Warren T Murphy, Son. 2106 C Clinton St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBELLAR HEMORRHAGE 431- DUE TO, OR AS A CONSEQUENCE OF: (b) HYPERTENSION 20 year (c) DIABETES MELLITUS 10 year					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) N/A					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 19 1979, to 11-8-79, that (I) (we) lost saw the deceased alive on 11-8-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. Morell				22c. DATE SIGNED 11-8-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVA M. MORELL				22e. ADDRESS 7936 OLD GEORGETOWN RD. BETH.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/13/1979		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, California		23e. DATE FILED BY REGISTRAR 25c. RECORDS SECTION			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.					

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

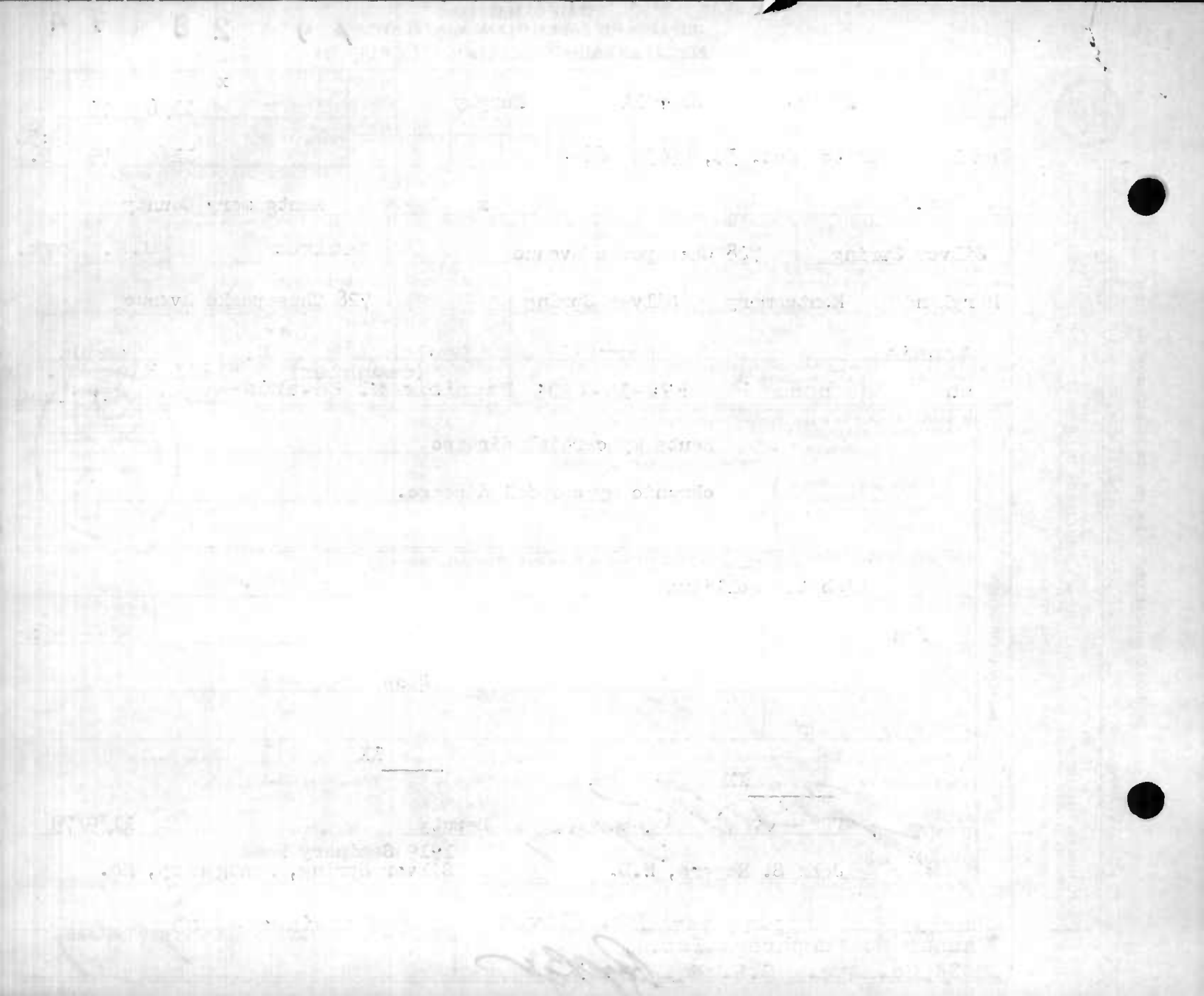
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Martha Sherill Murphy										2a. DATE KNOWN OF DEATH ESTIMATED 11/8 1979										2b. HOUR M							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1914		6. AGE (IN YEARS) LAST BIRTHDAY 66 1/2		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 11/8 1979										2d. HOUR 9:50 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.															
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 728 Chesapeake Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.															
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 728 Chesapeake Avenue											
14. FATHER'S NAME FIRST MIDDLE LAST Lonnie Sherrill						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah K. Teague						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no none								16b. SOCIAL SECURITY NO. 578-10-4639							
17. INFORMANT (daughter) Patricia M. Edwards-Olney, Maryland										ADDRESS 3321 King Wm. Dr.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Diabetes mellitus</u>																											
19a. DATE OF OPERATION None						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D. Deputy MEDICAL EXAMINER DATE SIGNED 11/9/79																											
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 11-13-1979						23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet															
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC						25a. DATE REC'D. BY REGISTRAR 11-13-79						25b. REGISTRAR'S SIGNATURE															
24. FUNERAL DIRECTOR Walter E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.																											





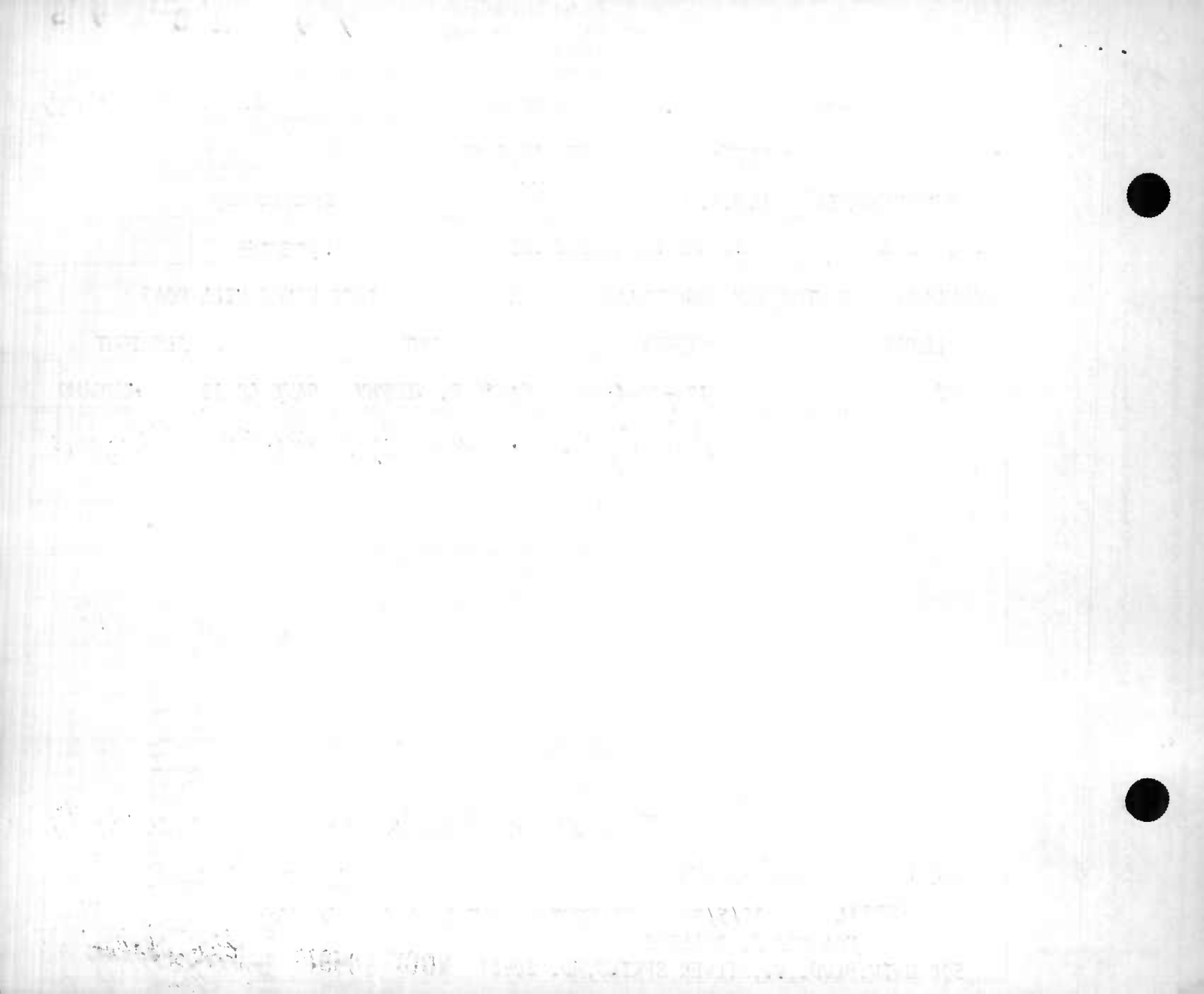


TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR 1 - STATE REGISTRAR											
REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH		MONTH DAY YEAR			
Patsy A. Murphy						11 5 79		2b HOUR			
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		
Female			WHITE		DEC 16, 1935		43		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.		
PENNSYLVANIA			U.S.A.				Montgomery				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda			Suburban Hospital			HOUSEWIFE					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1332 VETRS MILL ROAD			
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST LLOYD STEFFY					FIRST MIDDLE LAST RUTH ALBRIGHT						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS	
NO					195-28-4490		DAVID P. MURPHY			SAME AS 13 HUSBAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Right Parotid										5 years	
1420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 11/13/79, to 11/5/79, that (I) (we) last saw the deceased alive on 11/4/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)											
22b SIGNATURE						DEGREE			22c DATE SIGNED		
Bruce S. Bloom						M.D.			11/5/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS					
Bruce S. Bloom						5530 Wisconsin Ave					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION			
BURIAL			10/8/79		RIVERVIEW BURIAL PARK			CITY OR TOWN COUNTY STATE			
								LANCASTER PA			
24 FUNERAL DIRECTOR NAME						25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS						NOV 8 1979			[Signature]		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											



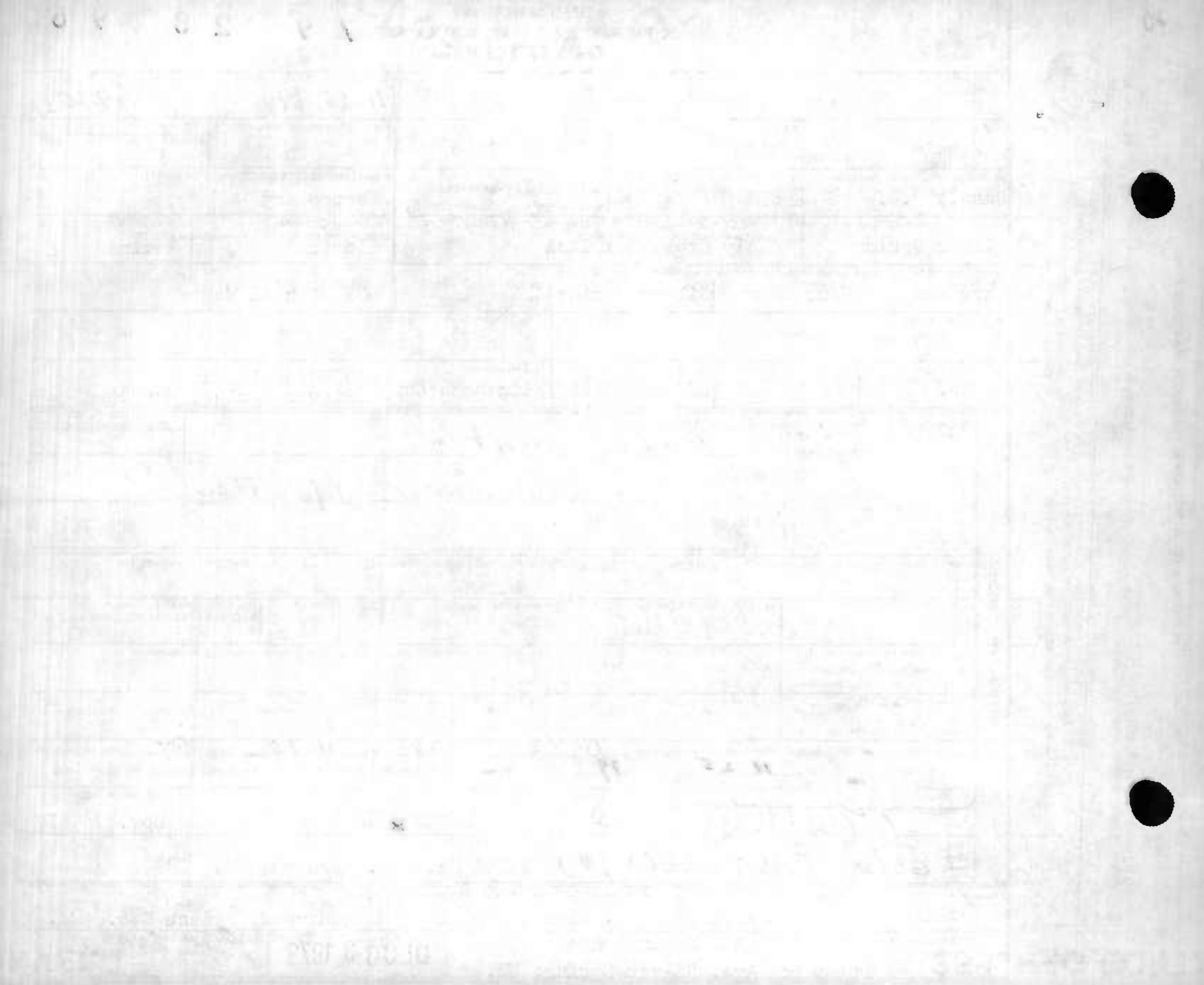
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 4 9 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Gertrude Murr				2a. DATE OF DEATH MONTH DAY YEAR 11. 25. 79			
3 SEX Female				7b. HOUR 4:50 A.M.			
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan 23, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7a. UNDER 1 YEAR MONTHS DAYS	
7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Lewis				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Von Rest			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 577-09-0082A		17 INFORMANT ADDRESS Elizabeth Cox, 605 Winhall Way Silver Spring, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from <u>11. 23.</u> , 19 <u>79</u> , to <u>11. 25.</u> , 19 <u>79</u> , that (he) (we) last saw the deceased alive on <u>11. 25.</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Felix Castellon, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov. 25, 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FELIX CASTELLON, M.D.				22e. ADDRESS 11141 Ga. Ave. Wheaton, Md. 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 28, 79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince Geo., Md.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR DEC 3 1979		25b. REGISTRAR'S SIGNATURE <u>Barney McCreedy</u>	
11800 New Hampshire Ave. Silver Spring, Md.							



NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BABETTE C. MYERS					2a. DATE OF DEATH MONTH DAY YEAR Nov 1 1979				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 1 1887		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD Montgomery Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 199 Rollins Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-1691		17. INFORMANT ADDRESS Silver Spring, Maryland Luiz Simmons 1320 Fenwick Lane.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Cardiac arrest/arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 20, 1979, to Nov 1, 1979, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on Oct 10, 1979, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> did not view the body after death.									
22b. SIGNATURE Patricia D. Kellogg MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/1/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA D. KELLOGG				22e. ADDRESS 809 Viers Mill Rd, Rockville, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-6-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA			
24. FUNERAL DIRECTOR Name Address Robert A. Pumphrey Funeral Homes P.A. 7557 Wisconsin Ave. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 09 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

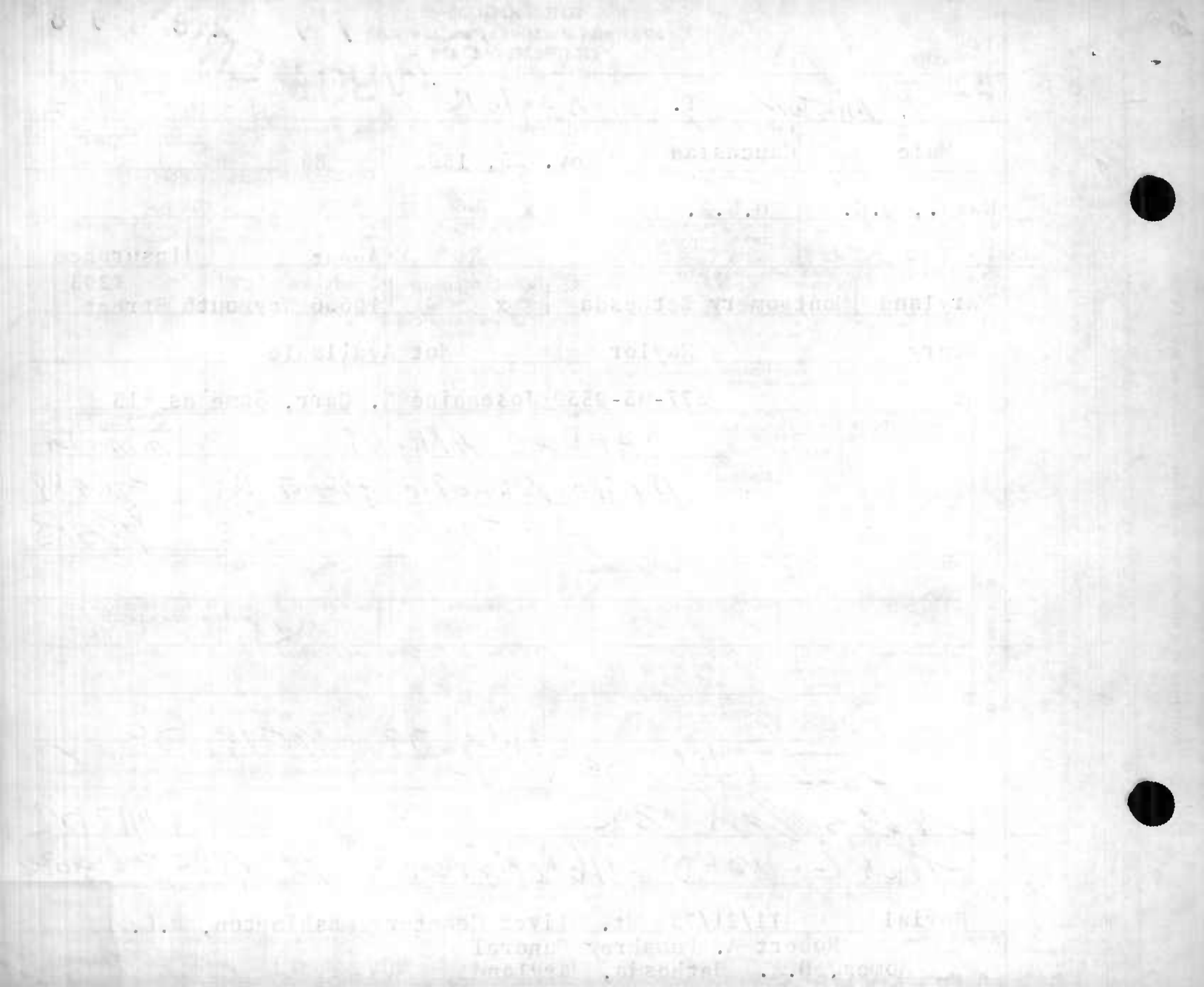
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 4 9 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
MILTON T. NAYLOR			11-18-79			11:00 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7a UNDER 1 YEAR		
Male	Caucasian	Nov. 25, 1892	86 YRS			8b UNDER 24 HRS		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c CITIZEN OF WHAT COUNTRY?			8c MONTHS		
Wash., D.C.			U.S.A.			DAYS		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Bethesda			Suburban Hospital			Agent		
13a STATE			13b COUNTY			13c CITY OR TOWN		
Maryland			Montgomery			Bethesda		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a STREET ADDRESS		
Henry			Not Available			#203		
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16c SOCIAL SECURITY NO.			17 INFORMANT		
no			577-03-9539			Josephine N. Carr, Same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST								minutes
4140								YEARS
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DIS								YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) ARTEROSCLEROSIS								YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART I OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								
22. I certify that (I) (the hospital) attended the deceased from July 19 79, to Nov 18 79, that (I) (we) last saw the deceased alive on 11/18 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
Thos G. Ward						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/18/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Thos G. Ward						6116 Robinwood Rd, Bethesda, Md 20834		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			11/21/79		Mt. Olivet Cemetery		Washington, D.C.	
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey Funeral Homes, B.A. Bethesda, Maryland			NOV 21 1979			[Signature]		







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Carroll Newman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 15 1979</b>			2b. HOUR <b>4:10 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 13, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASH. ADVENTIST HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Golf Course</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Md. Montg Silver Spring</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8500 16th STREET</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philmore Newman</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CORA Williams</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Leona Newman (Wife) Same AS #13</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> <b>185-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma bari, metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Causes of prostate, undifferentiated</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>months</b> <b>~ 1 yr.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>11/7</b> , 19 <b>79</b> , to <b>11/15</b> , 19 <b>79</b> , that (I) (last) saw the deceased alive on <b>11/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Fred W. Brennwald</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/15/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.W. BRENNWALD</b>					22e. ADDRESS <b>831 University Blvd E. Silver Spring Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-20-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Luckett's VA.</b>		
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>					24b. N. Wash. St. <b>Rockville, Md.</b>		25a. DATE REG'D. BY REGISTRAR <b>NOV 21 1979</b>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) PAUL EDWARD NEWMUM			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 1, 1979				2b. HOUR 3:20 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 19, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE OF RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Indiana			13b. CITY OR TOWN Park		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Route 1 (47832)		
14. FATHER'S NAME FIRST MIDDLE LAST James E. Newnum			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Edith Russell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 323-28-5458		17. INFORMANT same as #13 Mrs. Virginia Newnum, Wife (See Above)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 2028 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small Bowel Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Lymphoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 Min. 2 Days 4 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 10/30/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small Bowel Obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 10, 1979</u> to <u>November 1, 1979</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 1, 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.									
22b. SIGNATURE <u>B. Foster</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>11/1/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BRANDA Foster</u>						22e. ADDRESS <u>National Institutes of Health Clinical Center, Bethesda, Maryland 20205</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-4-79		23c. NAME OF CEMETERY OR CREMATORY Rush Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Tangier, Indiana			
24. FUNERAL DIRECTOR'S NAME <u>Robert A. Pumphrey Funeral Homes, P.A.</u> ADDRESS <u>7557 Wisconsin Ave., Bethesda, MD</u>						25a. DATE REC'D. BY REGISTRAR NOV 07 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Indiana

U.S.A.

Part

James

Newman

Robert

Russell

James as 12

222-22-2438

for

Bureau

11-4-73

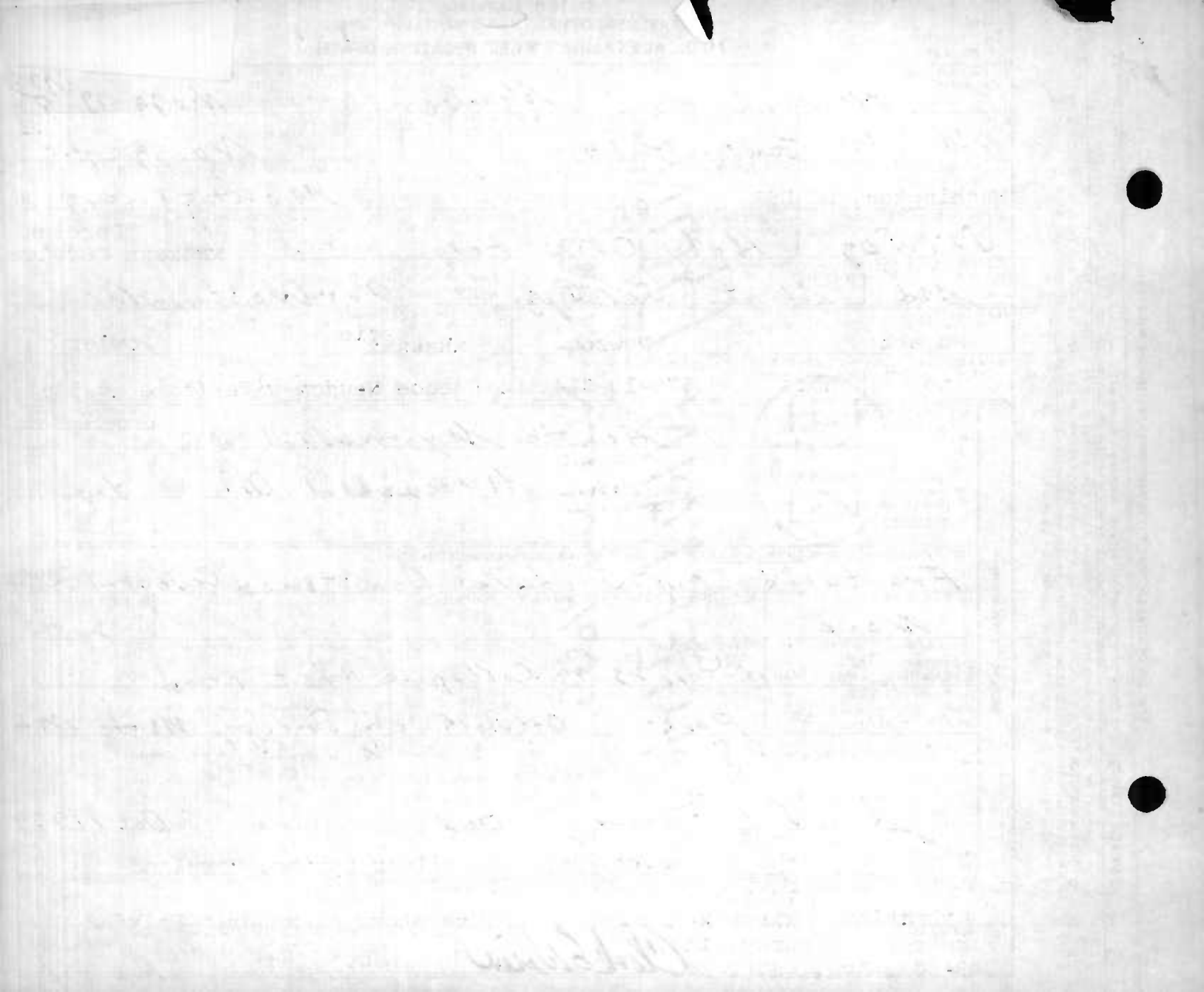
Green County, Indiana

Robert J. Murphy, General Agent, U.S.A.

7327 Wisconsin Ave., Bethesda, Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28501	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Howard F. Newsom</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Nov 29 1979</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 31 1864</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>64 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Nov 29 1979</b>		2b. HOUR <b>12:00</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Sil. Spg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Foreign Service</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Sil. Spg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Boul Woodmoor Dr.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hubert Newsom</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Fowler</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>578-10-9142</b>		17. INFORMANT ADDRESS <b>N. Dueece Newsom-wife-(same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4291</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Fractured Skull - Subdural Hematoma &amp; Cerebral Clot</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>11 23 1979</b>				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <b>11 23 1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Collapsed &amp; hit head</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Park</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Ottoburn Rd Sil Spg Mont MD</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>DME</b>				MEDICAL EXAMINER <b>John S. Rogers</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>				ADDRESS <b>Silver Spring, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>12-1-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Fairfax Va.</b>		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>										25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Clark E. Quinn</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or page 4 retained.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES G. Nicewarner			2a. DATE OF DEATH MONTH DAY YEAR 11 23 79		2b. HOUR 11 50 A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 17 1901	6. AGE (IN YEARS LAST BIRTHDAY) 78	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plasterer	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7719 Eastern Avenue
14. FATHER'S NAME FIRST MIDDLE LAST James H. Nicewarner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Melinda Hott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 212 12 4029	17. INFORMANT ADDRESS Robert J. Nicewarner 201 N. Van Buren St. Rockville Md.		

MEDICAL CERTIFICATION

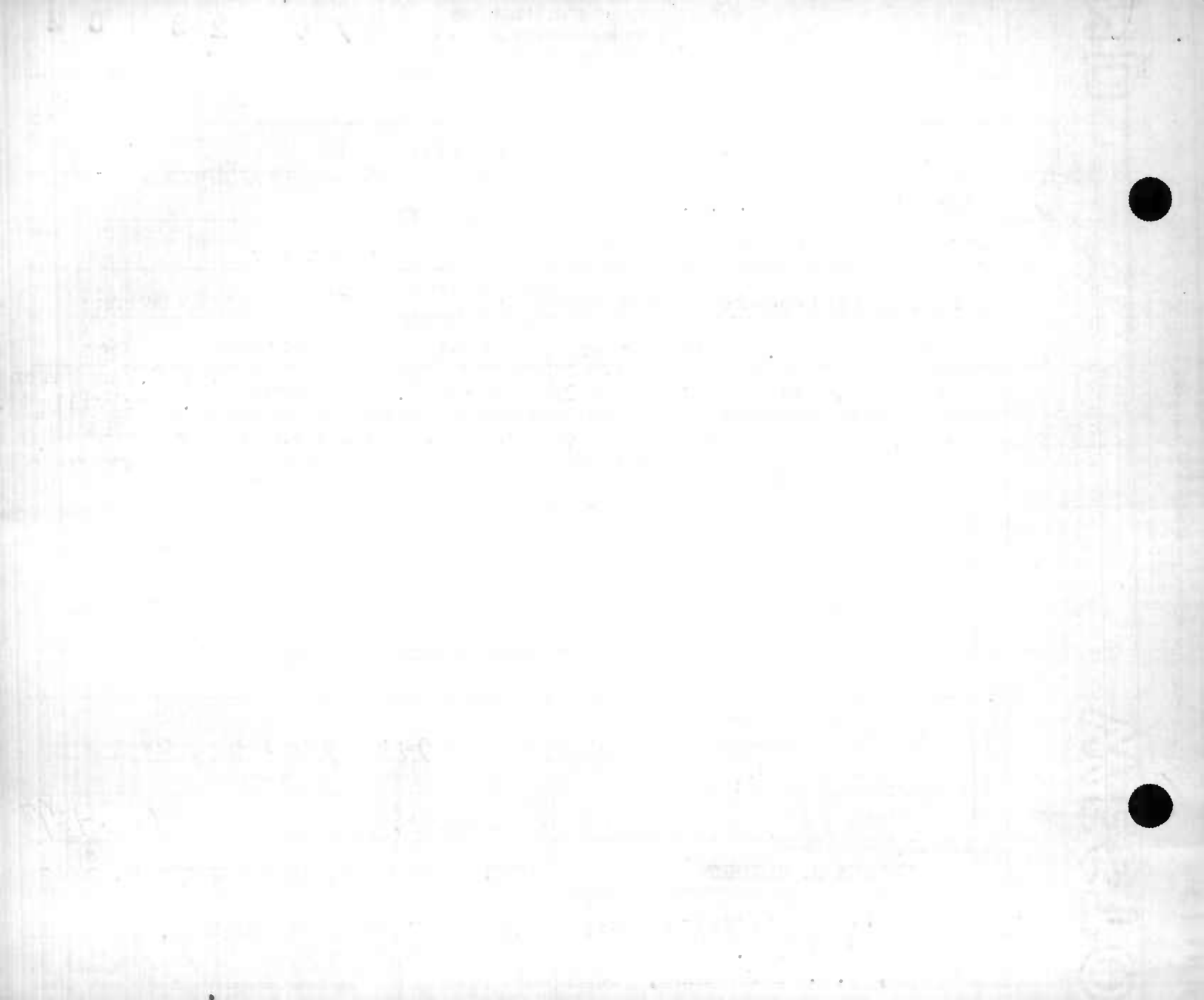
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Mesothelioma of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from before 11-15-79 to 11-23-79, that (I) (we) lost saw the deceased alive on 11-23-79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Physician) (did) (did not) view the body after death.			
22b. SIGNATURE Carrikk D. Nagibet		22c. DATE SIGNED 11-24-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARRIKK D. NAGIBET		22e. ADDRESS 10301 GEORGIA AVE., SILVER SPRING, MD. 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11/25/79	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND		25a. DATE REC'D. BY REGISTRAR NOV 29 1979	25b. REGISTRAR'S SIGNATURE History McBrady







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 5 0 3					
1. FOR STATE REGISTRAR				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Dorothy				Noakes				11-21-79				12 noon			
3. SEX				4. RACE				5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)			
Female				White				8-11-04				75			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington D.C.				U.S.A.								MONTGOMERY, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Adelphi				MANOR CARE Adelphi				HOT SHOPPE				RETIRED.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
Maryland				Montgomery				Takoma Park				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Louis P. Allen				Alphie Reynolds											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS			
No				579-48-6064				Nancy C. Kendig				10503 Edgely Dr. Adelphi Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROPRIATE INTERVAL BETWEEN ORGUT AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Moderately differentiated adenocarcinoma of Colon												9/78			
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic to Lymph Nodes, @ Femur,												9/78			
DUE TO, OR AS A CONSEQUENCE OF (c) Peritoneum (Ascites), Abdominal wall												9/78			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
Carcinoma tumor from ileocecal valve, Malnutrition, ASCVD															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
None				None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
No				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) <del>the hospital</del> attended the deceased from 11-1-79, 19, to 11-21-79, 19, that (I) <del>was</del> last saw the deceased alive on 11-13-79, 19, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
MBP. Patrick III MD								11-21-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
G.B. Patrick III MD				2222 Colesville Rd Silver Spring, Md 20910											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY			
Burial				Nov. 24-1979				Geddes Hill Cemetery				Suitland Rd Pikesville Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J.A. Walters Takoma F.H.				254 Carroll St, N.W. Wash., D.C. 20012				NOV 27 1978				History/McBryde			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP \_\_\_\_\_

DHMH-16 20M  
(VRS 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 28504

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY T. NORDAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-1-79</b>			2b. HOUR <b>12 P.M.</b>			
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 11 85</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.A.O.</b>	
13a. STATE <b>WASH. DC</b>				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bazarus Trammell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Murphree</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>577-38-7943A</b>		17. INFORMANT ADDRESS <b>Vienna, Va. 22180</b> <b>Clarence Nordan-son 2791-Chain Bridge Rd.,</b>			

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>4280</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Urinary tract infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive heart failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b> <b>Months</b>
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>diabetes mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>19 75</b> to <b>11-1-1979</b> , that (1) (we) last saw the deceased alive on <b>10-31-1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) had (did not) view the body after death.							
22b. SIGNATURE <b>W. Thaparo</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-1-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

5445

Items 4, 16b g539 1/2/80 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 0 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Eliseo Ralph Ochoa</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 - 23 - 1979</i>			2b. HOUR <i>12:30A.M.</i>			
3. SEX <i>M</i>		4. RACE <i>Caucasian</i> <del>BLK</del>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 - 14 - 35</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>44</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>McKEESPORT PENNA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY MD.</i>			
10. CITY OR TOWN OF DEATH <i>TACOMA PE. MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADJUTANT</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CONTROL OPERATOR</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>NATIONAL AIRPORT</i>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>			13b. COUNTY <i>MONTGOMERY</i>			13c. CITY OR TOWN <i>TACOMA PARK</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>7600 MAPLE AVE</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>RALPH OCHOA</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>FELICIA JASO</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>VI 1954-1955</i>		17. INFORMANT <i>TONI LLOYD</i>				ADDRESS <i>659 GRANT ST McKEESPORT PA</i>				

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Murder G1 Bleeding</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5728 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Liver failure and inadequate clothing for the</i>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) *Chronic*  
*alcoholism, alcoholic hyaline, hepatic encephalopathy, focal lesion, alcohol*

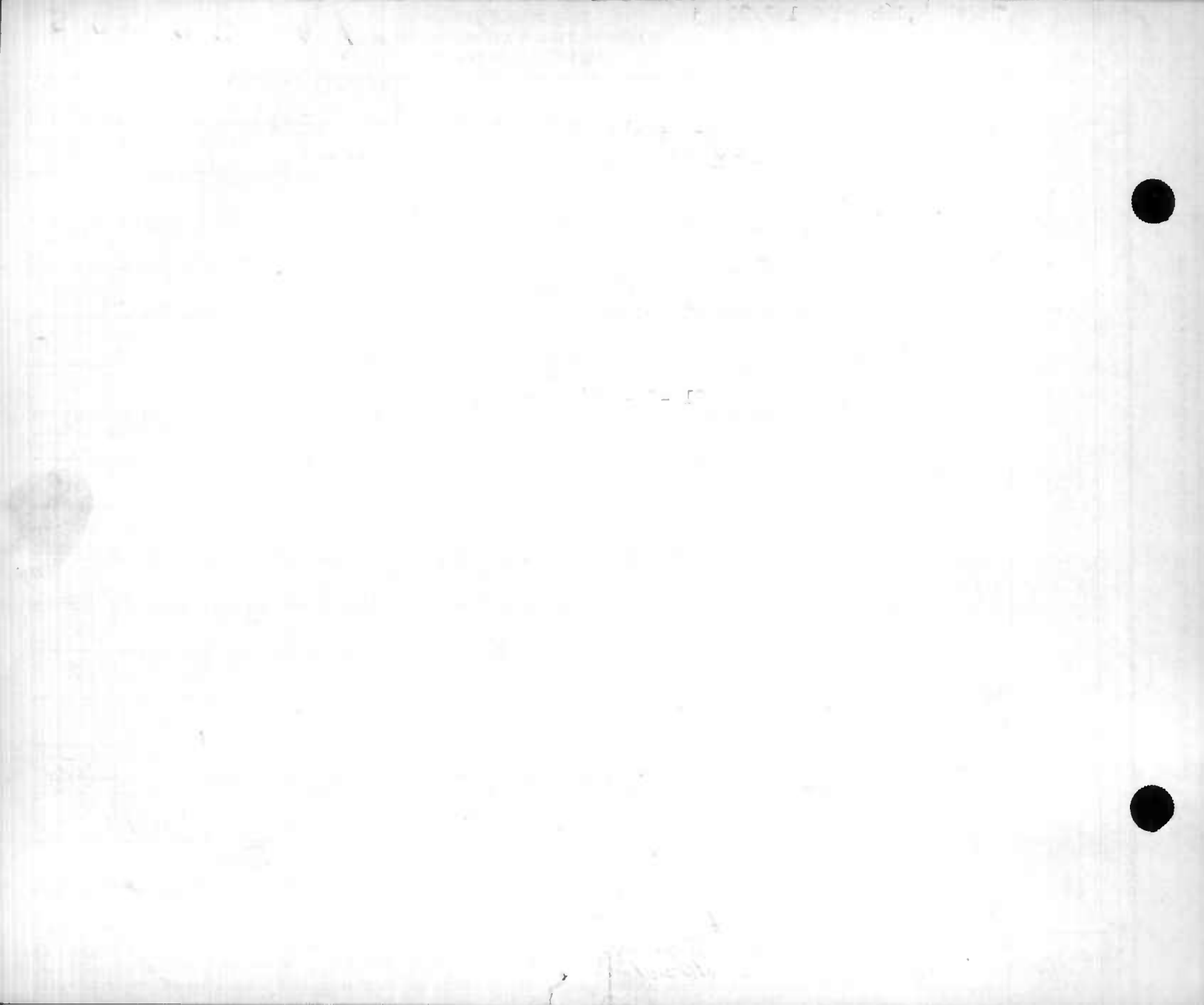
19a. DATE OF OPERATION <i>14 Nov 79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Thyroidectomy - prolonged respiratory support</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>26 Oct</i> , 19 <i>79</i> , to <i>23 Nov</i> , 19 <i>79</i> , that (1) <i>was</i> last saw the deceased alive on <i>23 Nov</i> , 19 <i>79</i> , and that in <i>my</i> opinion death occurred on the date and hour and from the causes stated above. (If <i>we</i> (did not) view the body after death.							
22b. SIGNATURE <i>William Gerling</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11-23-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>11-23-79</i>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <i>ST. MARYS</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>McKEESPORT ALLEGANY PA</i>	
24. FUNERAL DIRECTOR NAME <i>McGUIRE</i>				ADDRESS <i>7400 G.H. AVE NW</i>		25a. DATE RECD. BY REGISTRAR <i>NOV 29 1979</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	November 12 1979			8:15 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		
Female		Caucasian		May 9 1891		88		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Massachusetts		U.S.A.				Montgomery County MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville		11531 Cushman Road		Homemaker		Home		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS		
Maryland		Montgomery		Rockville		11531 Cushman Road		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		
John		Mary		No		028-28-8810		
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. DATE OF OPERATION		20a. AUTOPSY?		
Mary E. Haggerty		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malnutrition</u> Cardio respiratory failure		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Same as Above		(b) <u>malnutrition - protein wasting</u>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		
		(c) <u>malnutrition - protein wasting</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		
				21g. CITY OR TOWN		21h. COUNTY		
				21i. STATE		21j. DATE SIGNED		
				21k. SIGNATURE		21l. DATE SIGNED		
				21m. PHYSICIAN'S NAME (TYPE OR PRINT)		21n. ADDRESS		
				Timothy J. Spurling M.D.		Bethesda, Maryland		
				21o. NAME OF CEMETERY OR CREMATORY		21p. LOCATION		
				Holy Rosary		Spencer		
				21q. DATE REC'D. BY REGISTRAR		21r. REGISTRAR'S SIGNATURE		
				NOV 19 1979		Dorothy McBrady		

MEDICAL CERTIFICATION

BP







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 0 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST PATRICK MICHAEL O'CONNOR		MONTH DAY YEAR HOUR 11 20 79 5:45P M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)
MALE	WHITE	MONTH DAY YEAR April 7 1925	54 YRS.
7a BIRTHPLACE (STATE OR FOREIGN)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
NEW JERSEY	U.S.A.		Montgomery County MD.
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Bethesda	Clinical Center, Bethesda, Md (NIH)		12b KIND OF BUSINESS OR INDUSTRY ACCOUNTING
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b INSIDE CITY LIMITS?	13c STREET ADDRESS
13a STATE COUNTY New Jersey Bergen		13b YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	96 McNamee Street
14 FATHER'S NAME FIRST MIDDLE LAST William - O'Connor		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie - Toult	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W. II		16b SOCIAL SECURITY NO. 080-18-3177	
		17 INFORMANT ADDRESS Mrs. Madeline O'Connor, Wife (same as above)	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bleeding</u> 2028 DUE TO, OR AS A CONSEQUENCE OF (b) <u>thrombocytopenia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 mos. 8 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 8, 19 79, to November 20, 19 79, that <input checked="" type="checkbox"/> (we) lost the deceased alive on November 20, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.			
22b. SIGNATURE Joanne Tobacman M.D.		22c. DATE SIGNED 11.21.79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joanne Tobacman		22e. ADDRESS Nat'l. Inst. of Health - Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov/26/79	23c. NAME OF CEMETERY OR CREMATORY Calverton Cemetary	23d. LOCATION CITY OR TOWN COUNTY STATE Long Island Nassau New York
24 FUNERAL DIRECTOR NAME Chambers Funeral Home - Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 28 1979	
		25b. REGISTRAR'S SIGNATURE R. J. McCreedy	

10282

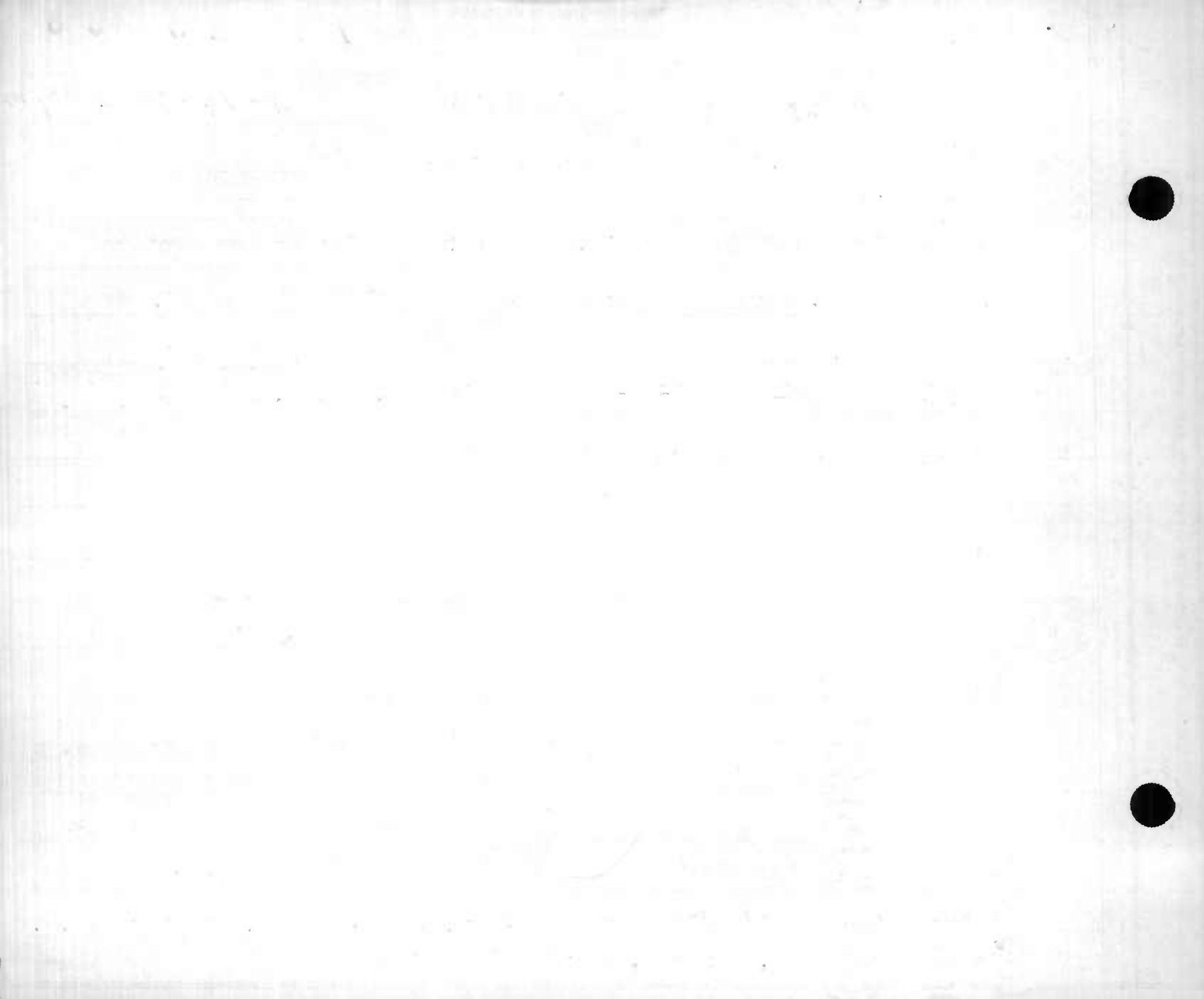
RECEIVED  
JAN 21 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 8 5 0 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) COLY M OLSON				2a. DATE OF DEATH 11-14-79		2b. HOUR 2:35pm	
3. SEX M		4. RACE W		5. DATE OF BIRTH 12-19-88		6. AGE (IN YEARS LAST BIRTHDAY) 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Broker		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Pr. George		13c. STREET ADDRESS Broadcreek	
14. FATHER'S NAME FIRST MATHIAS MIDDLE OLSON LAST OLSON				15. MOTHER'S MAIDEN NAME FIRST CAROLINE MIDDLE SIMONSEN LAST SIMONSEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 153-26-6844		17. INFORMANT Carolyn O. Dale	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 485- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29hr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Cardiovascular Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/27/79 to 11/14/79, that (I) (we) lost saw the deceased alive on 11/14/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Myron L. Lenkin				DEGREE MD		22c. DATE SIGNED 11/14/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN				22e. ADDRESS 2307 SHOREFIELD RD WATERLOO, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/15/79		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory, 4th Mass. Ave, Washington, D.C.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Clinton, Maryland				25a. DATE RECD. BY REGISTRAR NOV 20 1979		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Effie May Osborne</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 10, 1979</b>			2b. HOUR <b>6:40AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 11 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Timekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Const.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Burtonsville</b>		13e. STREET ADDRESS <b>3805 Bell Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Lee Livesay</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Dezie Martin</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-14-5211</b>		17. INFORMANT ADDRESS <b>William F. Osborne Burtonsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung &amp; metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arterio-sclerotic cardiovascular disease &amp; old CVA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> 19 <b>65</b> , to <b>Nov</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/9/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. Dement Bonifant MD</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>11/10/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Dement Bonifant, M. D.</b>					22e. ADDRESS <b>1811 Prince Philip Drive Olney, MD 20832</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/13/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burtonsville Mont Md.</b>		23e. DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE <b>NOV 13 1979</b>	
24. FUNERAL DIRECTOR NAME <b>Howard M. Fleck</b>					25. ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>				

1403 BP



342 COTTON LBER

1914



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 28510

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Paul H. OTTO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 30 1979</b>		2b. HOUR <b>11:33 A.M.</b>						
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 13 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		6b. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		6c. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>					
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Iron Works</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4620 N. Park Ave.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Louis H. Otto</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irma Fischbach</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>577-10-4127</b>		17 INFORMANT ADDRESS <b>Paul L. Otto 9918 Julliard Dr. Beth., Md.</b>					

## MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac dysrhythmia</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>3 months</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Oct 1, 1979</b> to <b>Nov-30, 1979</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Nov-30, 1979</b> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) (did) ( <del>not</del> ) view the body after death.							
22b. SIGNATURE <b>Augustus A. Aquino</b>		DEGREE		22c. DATE SIGNED <b>Dec-1, 1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Augustus A. Aquino, M.D.</b>		22e. ADDRESS <b>10401 Old Georgetown Rd. Bethesda, Md. 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/3/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Brentwood, Md.</b>	
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> NAME <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey M. Brady</b>	



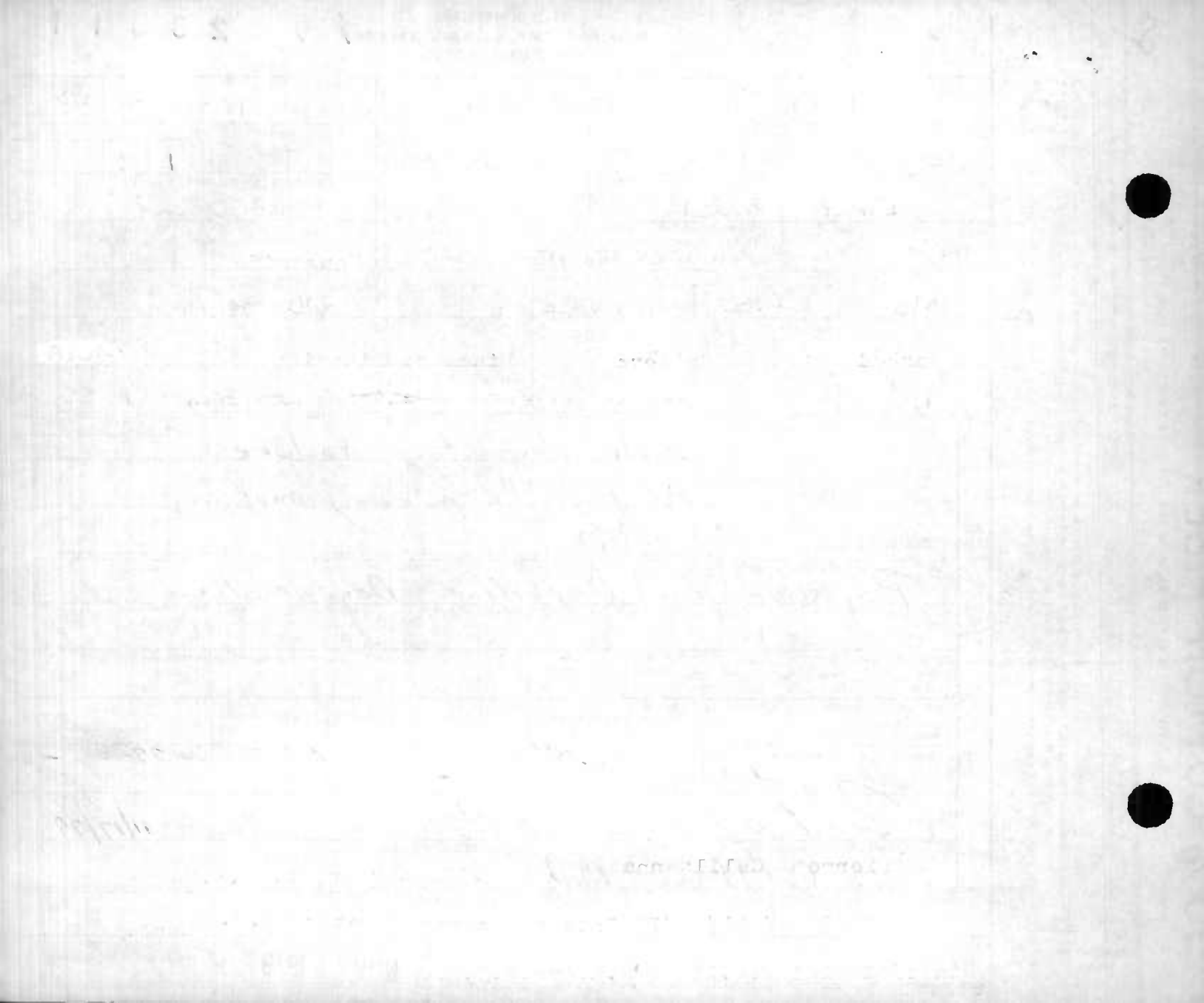


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 28511	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THERESA PANESSIDI</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11-17-79</b>		2b. HOUR <b>820</b> A.M.			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 24 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>79 2 7</b>		IF UNDER 1 YEAR IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>A U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6400 8th AVE.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Antonio Collova</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vincenzo DiCovi</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579 05 43145</b>		17. INFORMANT <b>Frank Galipo</b>		ADDRESS <b>1205 GALWAY DR. S.S., Md</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Past traumatic pulmonary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Progressive Spinal Cerebellar Degeneration</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> , 19 <b>79</b> , to <b>11/17</b> , 19 <b>79</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>11/17</b> , 19 <b>79</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <b>Pierre Calilhanna M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/17/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Pierre Calilhanna M.D.</b>		22e. ADDRESS <b>1109 Spring St. S.S.Md</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mont Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Hines/Rinaldi</b>					

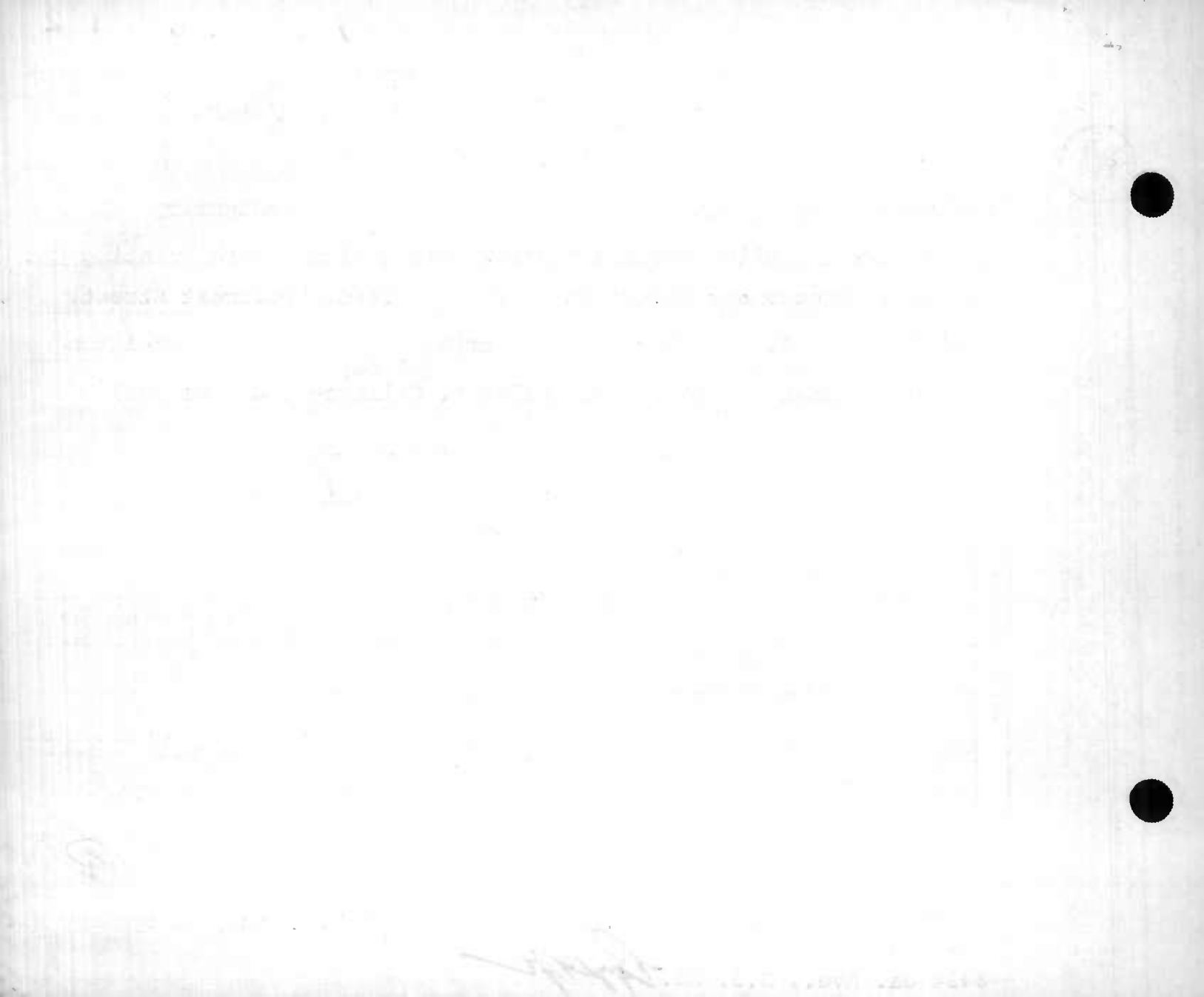


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 5 1 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Vivian M. Parker</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Nov 27 1979</b>		2b. HOUR <b>11:23 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 21 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sligo Gardens Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WEBB Printing Co.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William A. Parker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Hamilton</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>578-01-8319</b>		17. INFORMANT (niece) <b>Helen A. Sellers-</b>		ADDRESS (same as 13e) <b>14603 Woodcrest Street,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia</b> <b>4340</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with Multiple Cerebral Thromboses</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Recent Left Hemiplegia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 3 1979</b> to <b>Nov 27 1979</b> , that (I) (was) lost saw the deceased alive on <b>Nov 26 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Richard L. Whelton MD</b>				22c. DATE SIGNED <b>DEC 4 1979</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD L. WHELTON MD</b>	
22e. ADDRESS <b>7100 Baltimore Ave College Park</b>				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-30-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sil. Spring Montgomery Md.</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John M. Brady</b>	
26. ADDRESS <b>8434 Ga. Ave., S.S. Md.</b>							



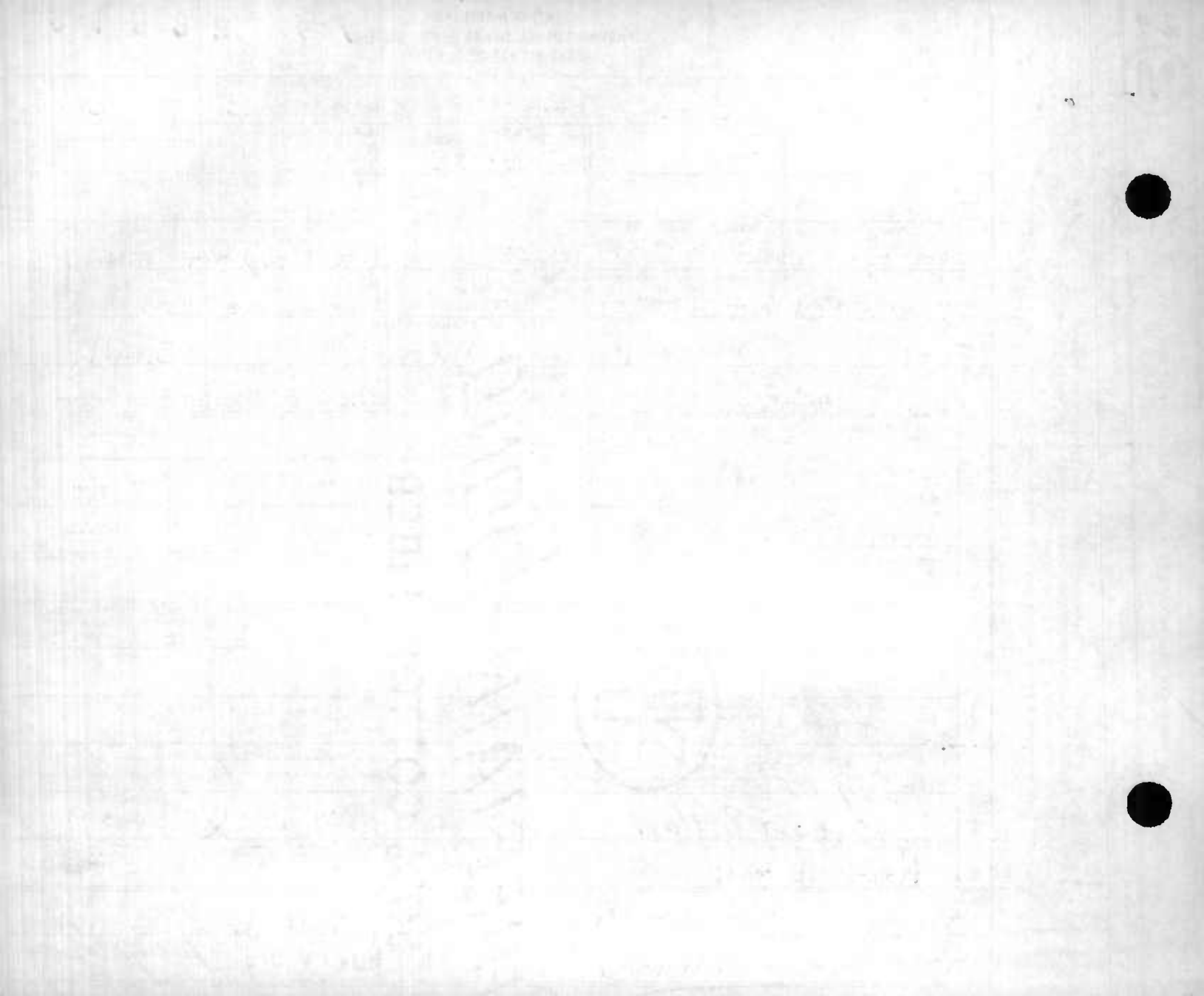
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 7 9 2 8 5 1 3				
1. DECEASED NAME (TYPE OR PRINT) George Edward Pennell					2a. DATE OF DEATH MONTH DAY YEAR November 13, 1979			2b. HOUR 5:45 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 11 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Navy Ret		12b. KIND OF BUSINESS OR INDUSTRY Military	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Calvert 13c. CITY OR TOWN Rosehaven N. Beach					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 628 Alabama Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Earl Pennell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST William Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 49-53		17. INFORMANT Jessie L. Pennell (wife)		ADDRESS Same as Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 1729 } DUE TO, OR AS A CONSEQUENCE OF Pneumonia 2 Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF Metastatic Melanoma 5 Years (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from 5 November 1979 to 13 November 1979, that (we) lost saw the deceased alive on 13 November 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (this hospital) view the body after death.									
22b. SIGNATURE Robert E. Hall				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-13-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Hall				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 16 79		23c. NAME OF CEMETERY OR CREMATORY Md Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham PG Md			
24. FUNERAL DIRECTOR NAME Rausch Funeral Home				ADDRESS Owings Md		25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

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1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>PAULINE MARY PERKINS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-5-79</i>			2b. HOUR <i>6:45 P</i> M	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>AUG 13, 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CREDIT OFFICE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RALEIGH'S</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>				13b. COUNTY <i>PRINCE GEO.</i>		13c. CITY OR TOWN <i>TAKOMA PARK</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>1110 HOLTON LANE</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>PAUL</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>NELLIE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>579-09-6685</i>		17. INFORMANT ADDRESS <i>ARCHIE P. PERKINS SAME AS 13 HUSBAND</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 2765 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>malnutrition</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>dehydration</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>19 74</i> to <i>11-5</i> <i>19 79</i> , that (I) (we) last saw the deceased alive on <i>11-5</i> <i>19 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M SNOW MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M SNOW MD</i>				22e. ADDRESS <i>9013 FLOWER AVE SILVER SPRING</i>			
23a. BURIAL, CREMATION, REMOVAL (BURIAL)		23b. DATE <i>11/9/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>FRANCIS J. COLLINS</i> <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 8 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

THIS DEATH CERTIFICATE IS TO BE FILED WITHIN 24 HOURS AFTER DEATH. IT IS TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN. THE LOW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IT IS TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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25/6/88

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
Mary		Elizabeth		Pidgeon				20. DATE PRONOUNCED DEAD		11/24		1979						1:05 P.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE		MONTH		DAY		YEAR	
Female		White		Aug. 2, 1890		89 YRS.		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Wadesville, Va.		USA										Montgomery County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Olney		17340 Quaker Lane		Ret. U.S. Government															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Olney				YES <input type="checkbox"/> NO <input type="checkbox"/>		17340 Quaker Lane									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST					
Lewis						Pidgeon		Susan Talbot Williams											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
None		226-60-4344		Edward Lewis Berry-nephew		Raleigh, N.C. 27614													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Acute myocardial disease		DUE TO, OR AS A CONSEQUENCE OF													
4291		Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		chronic cardiorespiratory disease.		DUE TO, OR AS A CONSEQUENCE OF											
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		P.M. 19		None															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion											
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
John S. Rogers, M.D.		Deputy		11/25/79															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
John S. Rogers, M.D.		1919 Seminary Road Silver Spring, Montgomery, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Cremation		11-25-79		Lee's Crematory		Washington, D.C. 20002													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Lee Funeral Home		300-4th St. N.E. Wash. D.C. 20002		NOV 28 1979		[Signature]													

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGES 1 AND 2 OF YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. BELMONT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic ant, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 28516

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn S. Littleman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-28-79</b>			2b. HOUR <b>8:30 PM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9-28-16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesperson</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Photography</b>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1111 University Blvd. W.</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>			

14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris Samet</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Molly Kobrinsky</b>	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>107-16-5631</b>	17. INFORMANT ADDRESS <b>Gregory Kaye; 421 Christopher Ave, Gaithersburg Md.</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			<b>6 months</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Brain tumor -</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic disease -</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION <b>10/10/79</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain tumor -</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **10/10** 19 **79** to **11/28** 19 **79**, that (I) (we) last saw the deceased alive on **11/28** 19 **79**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Octavio P. Blanco, MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>11/28/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Octavio P. Blanco, MD</b>		22e. ADDRESS <b>7910 Woodmont Ave. Bethesda.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-30-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Judean Mem. Gardens</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Montgomery, Maryland</b>
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24. FUNERAL DIRECTOR NAME <b>Danzan-Goldberg Chapels; 1170 Rockville Pike</b>	ADDRESS <b>Rockville, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>	25b. REGISTRAR'S SIGNATURE <b>Gregory Kaye</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>HARRY Bateman POLLOCK</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 24 79</b> 2b. HOUR <b>7:12AM</b>				
3. SEX <b>M</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 26 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS. <b>9</b> MONTHS <b>9</b> DAYS		7. IF UNDER 1 YEAR <b>9</b> DAYS <b>9</b> HOURS <b>9</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Popco</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13e. STREET ADDRESS <b>"Bayla 8 N. Summit Ave., Gardens"</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dr. Joseph W. Pollock</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Golda Davis Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>577-09-3927</b>		17. INFORMANT <b>Hazel W. Byrne</b>		17a. ADDRESS <b>17709 Parkridge Drive, Gaithersburg, Md. 20760</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic lung disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/15 1978</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> 19 <b>78</b> , to <b>11/24</b> 19 <b>79</b> , that (I) (we) saw the deceased alive on <b>11/24</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Myron L. Lenkin</b> MD					22c. DATE SIGNED <b>11/24/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>		
22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON MD 20902</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 28, '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gaithersburg Montg. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Gartner-Sandison F. N.</b>		24b. ADDRESS <b>316 E. Diamond Ave., Gaithersburg, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barney McBrady</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 9 2 8 5 1 8	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ETHEL I POTE			2a. DATE OF DEATH MONTH DAY YEAR 11/29/79		2b. HOUR 8:30 P M	
3 SEX F	4 RACE W.	5. DATE OF BIRTH MONTH DAY YEAR 3 4 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			10. CITY OR TOWN OF DEATH SILVER SPRING			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1504 SANFORD ROAD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUYER		12b. KIND OF BUSINESS OR INDUSTRY HAHN SHOE CO.	
13a. STATE MARYLAND			13b. CITY OR TOWN MONTGOMERY		13c. STREET ADDRESS 1504 SANFORD ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-09-1751		17. INFORMANT FRIEND ADDRESS GLADYS HEALEY 9711 49TH PL COLLEGE PARK, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days DXR.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/25/79, to 11/27/79, that (I) (we) lost saw the deceased alive on 10/25/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE S. J. COLLINS, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/27/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN				22e. ADDRESS 8630 FENOM ST. SILVER SPRING, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/30/79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR DEC 3 1979		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25b. REGISTRAR'S SIGNATURE [Signature]		

BP



600 UNIV. RD. W. SILVER SPRING, MD. 20901  
FRANCIS J. COLLINS  
1730429 CEDAR HILL

DEC 3 1952  
SUITLAND

FBI DET. MD.  
*[Signature]*

ESTABLISHED

*[Handwritten signature]*

*[Faint, mostly illegible handwritten notes and signatures]*

NO

677-02-1751

GLADYS HEALEY

FRIEND

UNKNOWN

UNKNOWN

MARYLAND MONTGOMERY SILVER SPRING X 1804 SAIFORD ROAD

SILVER SPRING 1804 SAIFORD ROAD

BUYER

ILAHN SHOD CO.

WASHINGTON, D. C. U.S.A.

X

MONTGOMERY

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 1 9

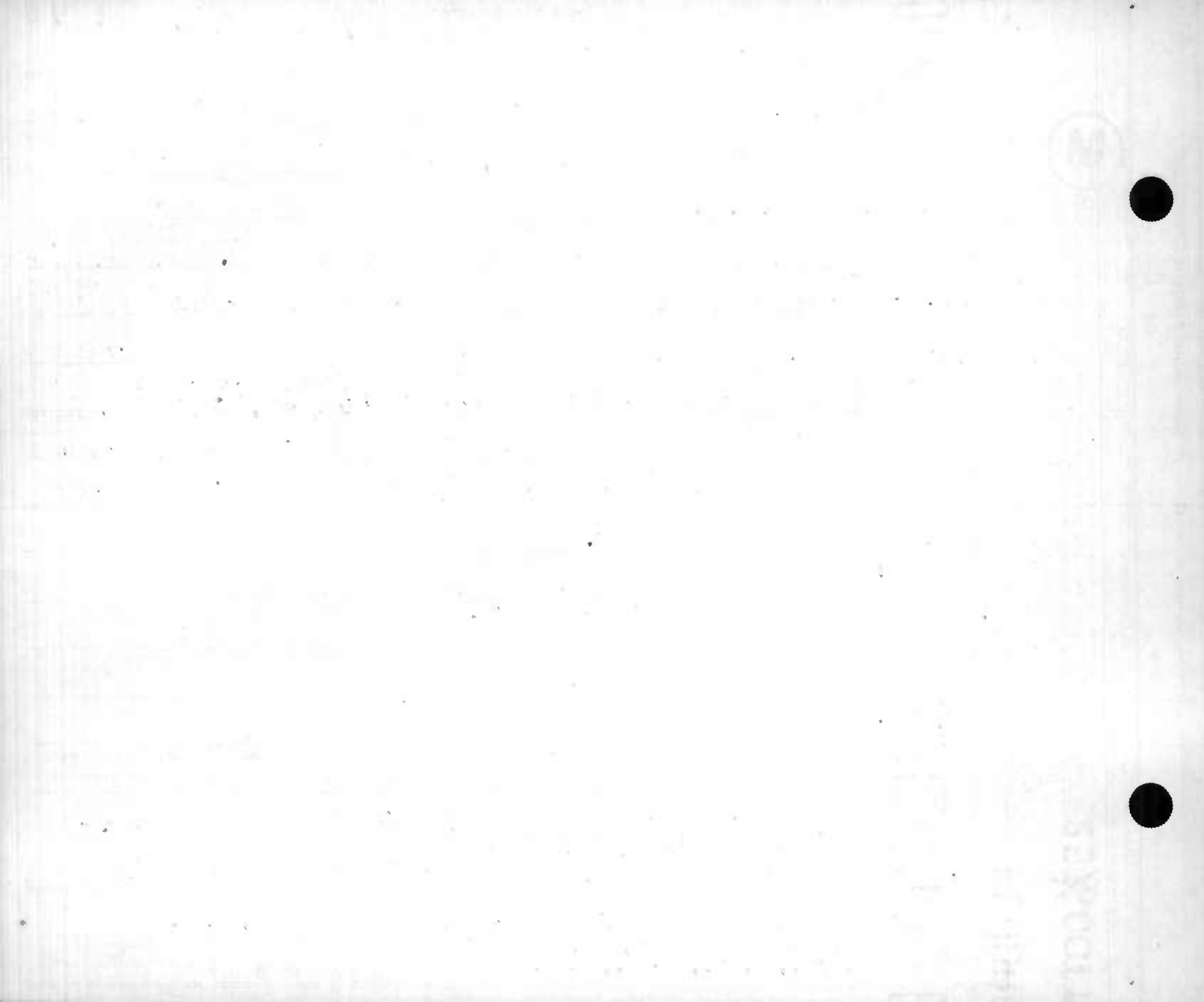
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES R. PRIME</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 18 79</b>			2b. HOUR <b>4:30 AM</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 1, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Statistical asst.</b>		12b. KIND OF BUSINESS OR INDUSTRY ASSOC. <b>of Amer. Railroad</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5308 Augusta Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles C. Prime</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Davidson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>718-10-7479</b>		17. INFORMANT ADDRESS <b>Alice A. Prime 5308 Augusta Street Bethesda, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>515-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Intermittent Pulmonary Fibrosis</b> (c) <b>Tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>9 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Possible Pulmonary Infection or Inflammation</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:30 11 18 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>March</b> 19 <b>79</b> , to <b>11-18-79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>8:24 11-17 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. J. Mc Carthy</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-18-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT J. MC CARTHY</b>				22e. ADDRESS <b>1145 19th St. N.W. WASH. DC. 20036</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-21-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., N. W., Wash., D. C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert J. McCarthy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

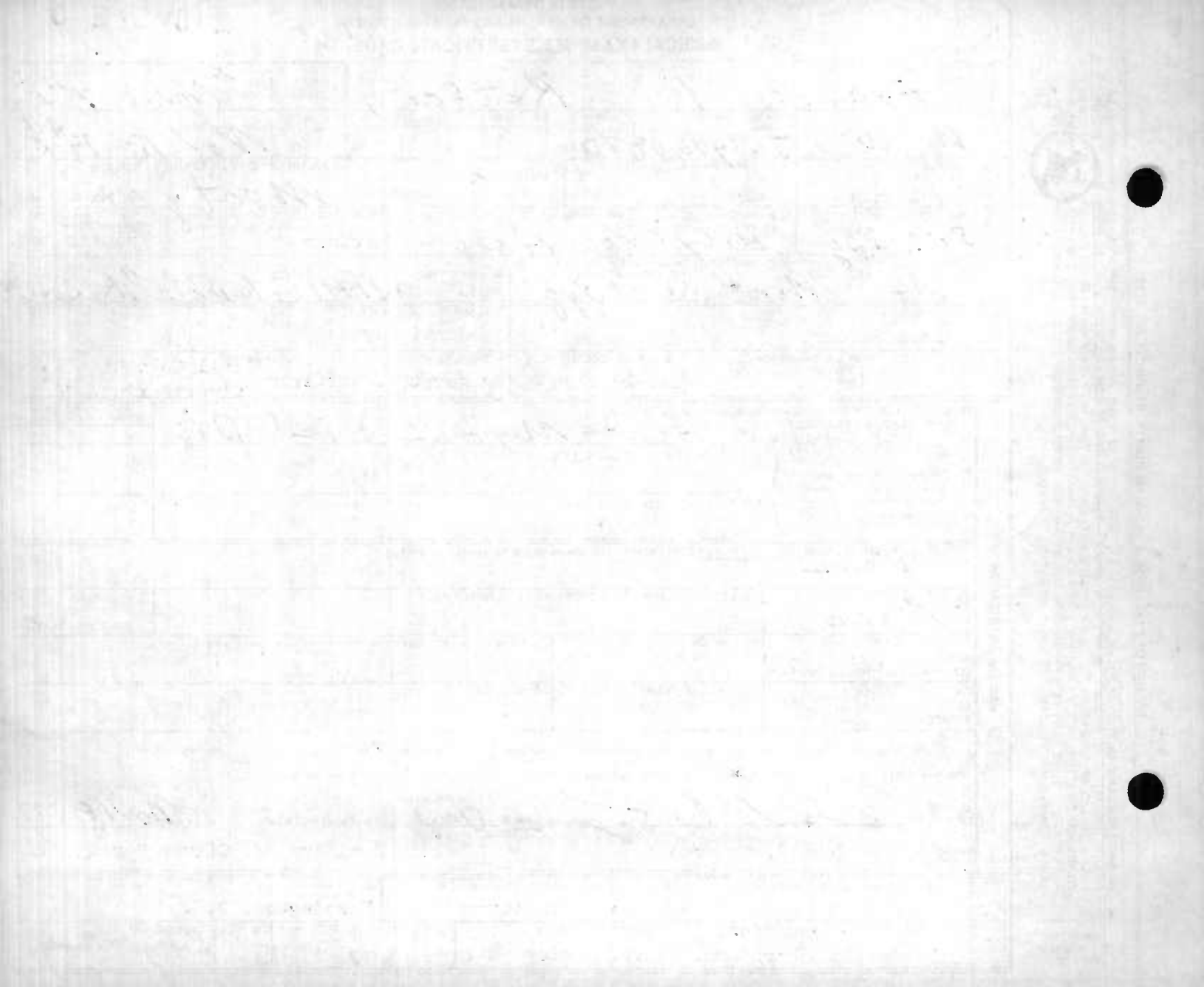
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If the deceased was injured, the medical examiner will be notified.

IMPORTANT: If the deceased was injured, the medical examiner will be notified.



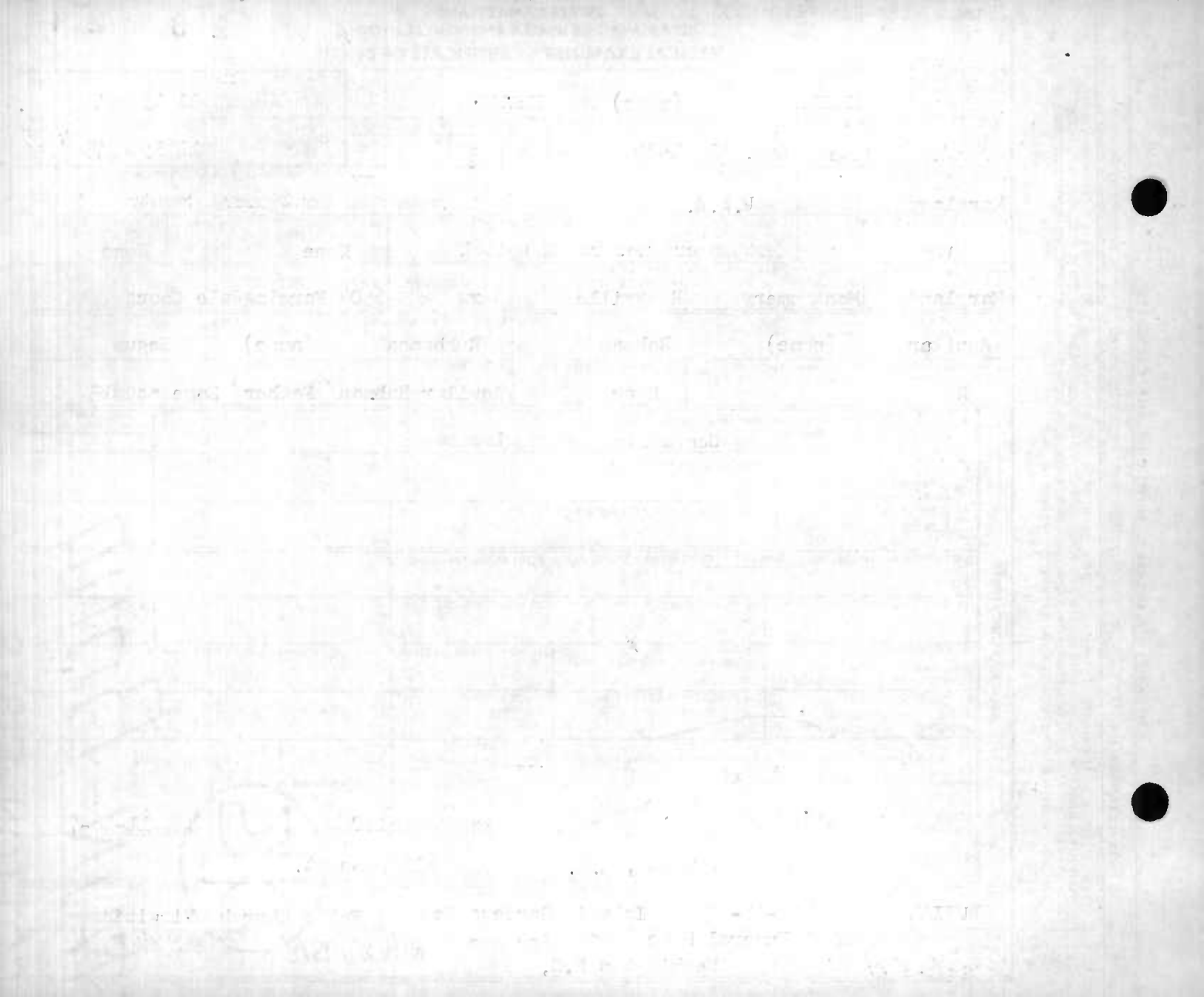
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Francis R. Rafferty</i>										2a. DATE KNOWN OF DEATH ESTIMATED <i>Nov. 18 1979</i>										2b. HOUR <i>4 AM</i>	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 10, 09 70</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>70 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <i>Nov. 18 1979</i>		2d. HOUR <i>4 PM</i>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>									
10. CITY OR TOWN OF DEATH <i>Silver Spg</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Driver</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Transit Ret.</i>									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE <i>MD</i>		13b. COUNTY <i>Montg</i>		13c. CITY OR TOWN <i>Silver Spg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>11411 Columbia Pike Apt 04</i>													
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Rafferty</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jennie Ryan</i>																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>					16b. SOCIAL SECURITY NO. <i>161-10-0184</i>					17. INFORMANT ADDRESS <i>Margaret R. Rafferty 11411 Columbia Pike Silver Spring, Md</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> <i>4291</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>																					
19a. DATE OF OPERATION <i>None</i>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>John S. Rogers</i>					TITLE (SPECIFY) <i>MD.</i>					DATE SIGNED <i>Nov 18 1979</i>											
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>					ADDRESS <i>1919 Seminary Rd. Silver Spring, Md.</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>					23b. DATE <i>Nov. 18, 79</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>											
23d. LOCATION CITY OR TOWN <i>Washington, D.C.</i>					COUNTY <i></i>					STATE <i></i>											
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home</i>					ADDRESS <i>11800 New Hampshire Ave. Silver Spring, Md.</i>					25a. DATE REC'D. BY REGISTRAR <i>NOV 21 1979</i>											
					25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>SHAHZEE (none) RAHMAN</b>										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11 15 19 79</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 11 1979</b>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS YRS. <b>3 3</b>		IF UNDER 1 YR. HOURS MIN. <b>3</b>		2b. HOUR <b>7:35 P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Montgomery</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>6504 Farmingdale Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aquilar (none) Rahman</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rukhsana (none) Begum</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Aquilur Rahman/ Father/ Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>1469 IMMEDIATE CAUSE (a) Congenital heart disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>11-16-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>11-17-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Islamic Gardens Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>DeVol Funeral Home</b> ADDRESS <b>2222 Wisc Ave Washington D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>				25b. REGISTRAR'S SIGNATURE <i>Anthony McBratney</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 5 2 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Edmund Bush REDINGTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 1 1979</b>		2b. HOUR <b>4:05A M</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Oct. 24 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Coast Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Virginia</b> 13b. COUNTY <b>Fairfax</b> 13c. CITY OR TOWN <b>Springfield</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5218 Light Street 22151</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George F. Redington</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fanny Wilcox</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1942-57</b>		17. INFORMANT ADDRESS <b>Hackensack, N.J.</b> <b>George F. Redington 210 Willow Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE BRONCHIAL PNEUMONIA</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHIOGENIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I/ (this hospital) attended the deceased from <b>Oct. 24</b> , 19 <b>79</b> , to <b>Nov. 1</b> , 19 <b>79</b> , that (I/ (we) last saw the deceased alive on <b>Nov. 1</b> , 19 <b>79</b> , and that in my/ (our) opinion death occurred on the date and hour and from the causes stated above. (I/ (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James M. Tucci MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>Nov. 1, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES M. Tucci</b>				22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Troy, Bradford Pennsylvania</b>	
24. FUNERAL DIRECTOR NAME <b>DeMaine Funeral Home</b> ADDRESS <b>Springfield, Va. 22151</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 05 1979</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>			





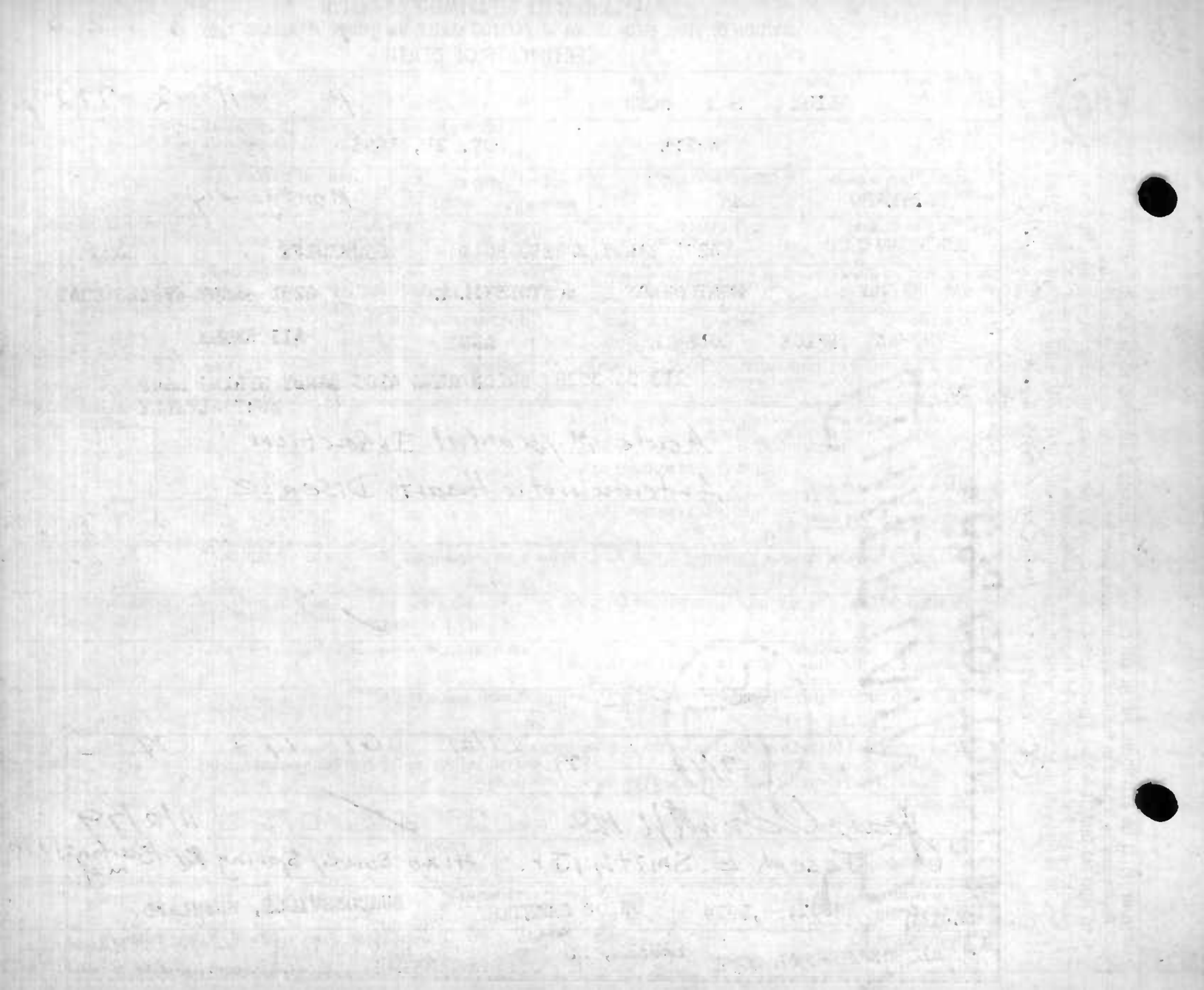
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>ALICE MAE RENN</b>			2a. DATE OF DEATH Month <b>11</b> Day <b>2</b> Year <b>79</b>		2b. HOUR <b>245</b> P.M.
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>NOV. 21, 1895</b>		6. AGE (In years last birthday) <b>83</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b>		Md.			
10. CITY OR TOWN OF DEATH <b>BURTONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4201 SANDY SPRING ROAD</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BURTONSVILLE</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>4201 SANDY SPRING ROAD</b>			
14. FATHER'S NAME First Middle Last <b>THOMAS BRICE CONNELL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNE AITCHESON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213 36 3528</b>		17. INFORMANT Address <b>BRICE RENN 4105 SANDY SPRING ROAD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/21</b> , 19 <b>76</b> , to <b>11/2</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>9/18</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph E. Smith, Jr.</b> DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/2/79</b>	
22d. PHYSICIAN'S NAME (Type) <b>Joseph E. Smith, Jr.</b>		22e. ADDRESS <b>4140 Sandy Spring Rd Burtonsville Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>NOV. 6, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>	
23d. LOCATION (City or Town) (County) (State) <b>BURTONSVILLE, MARYLAND</b>					
24. FUNERAL DIRECTOR <b>DONALDSON FUNERAL HOME</b>		ADDRESS <b>LAUREL, MD</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>Barry McCreedy</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Cleared with medical examiner 11/2/79*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 8 5 2 4	
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST <u>ROSE</u> MIDDLE <u>M</u> LAST <u>RICH</u> <u>Rose M. Rich</u>					MONTH <u>Nov</u> DAY <u>4</u> YEAR <u>79</u>					8:30 P.M.	
3. SEX <u>FEMALE</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>3</u> DAY <u>16</u> YEAR <u>89</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u>		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery &amp; County, MD.</u>					
10. CITY OR TOWN OF DEATH <u>Wheaton</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Randolph Hills Nursing Home</u>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Chief Operator</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>C &amp; P Tel. Co.</u>	
13a. STATE <u>D.C.</u>		13b. COUNTY <u>None</u>		13c. CITY OR TOWN <u>Washington</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>4927 Eskridge Ter. N.W.</u>			
14. FATHER'S NAME FIRST <u>Anthony</u> MIDDLE <u></u> LAST <u>Coggins</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Catherine</u> MIDDLE <u></u> LAST <u>O'Donnell</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>577-01-1036</u>		17. INFORMANT ADDRESS <u>Wheaton, Dalewood Dr. Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic Heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>18 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u></u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u></u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/3/77</u> 19 <u>77</u> , to <u>11/7/79</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Oct 23</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Michael R. Dobardge M.D.</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>Nov 4, 1979</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael R. Dobardge M.D.</u>				22e. ADDRESS <u>13975 Connecticut Ave Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11/7/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash., D.C. 20016</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 09 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Barry McBrady</u>					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 2 8 5 2 5				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLIE RICHARDSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 17, 1979</b>			2b. HOUR <b>8:15A<sub>M</sub></b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 16 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SLIGO GARDENS NURSING HOME</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONSTRUCTION WORKER</b>			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>PRINCE GEORGES SEAT PLEAS.</b>		13c. CITY OR TOWN <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13d. STREET ADDRESS <b>5016 NASH STREET,</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN RICHARDSON</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SALLEY SMITH</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>242 26 0448</b>		17. INFORMANT ADDRESS <b>GENEVA RICHARDSON SAME AS ITEM #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>lyng cancer with brain metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MO.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 15</b> , 19 <b>77</b> , to <b>Nov 17</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 15</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death).									
22b. SIGNATURE <b>Deborah Goldberg</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Nov 19, 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DEBORAH GOLDBERG, M. D.</b>				22e. ADDRESS <b>1106 SPRING STREET, SILVER SPRING, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-21-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOVER, MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>VANN &amp; WILLIAMS 4804 GA., AVE., N. W., D. C.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b>					
25b. REGISTRAR'S SIGNATURE									



# MAINTENANCE RECORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

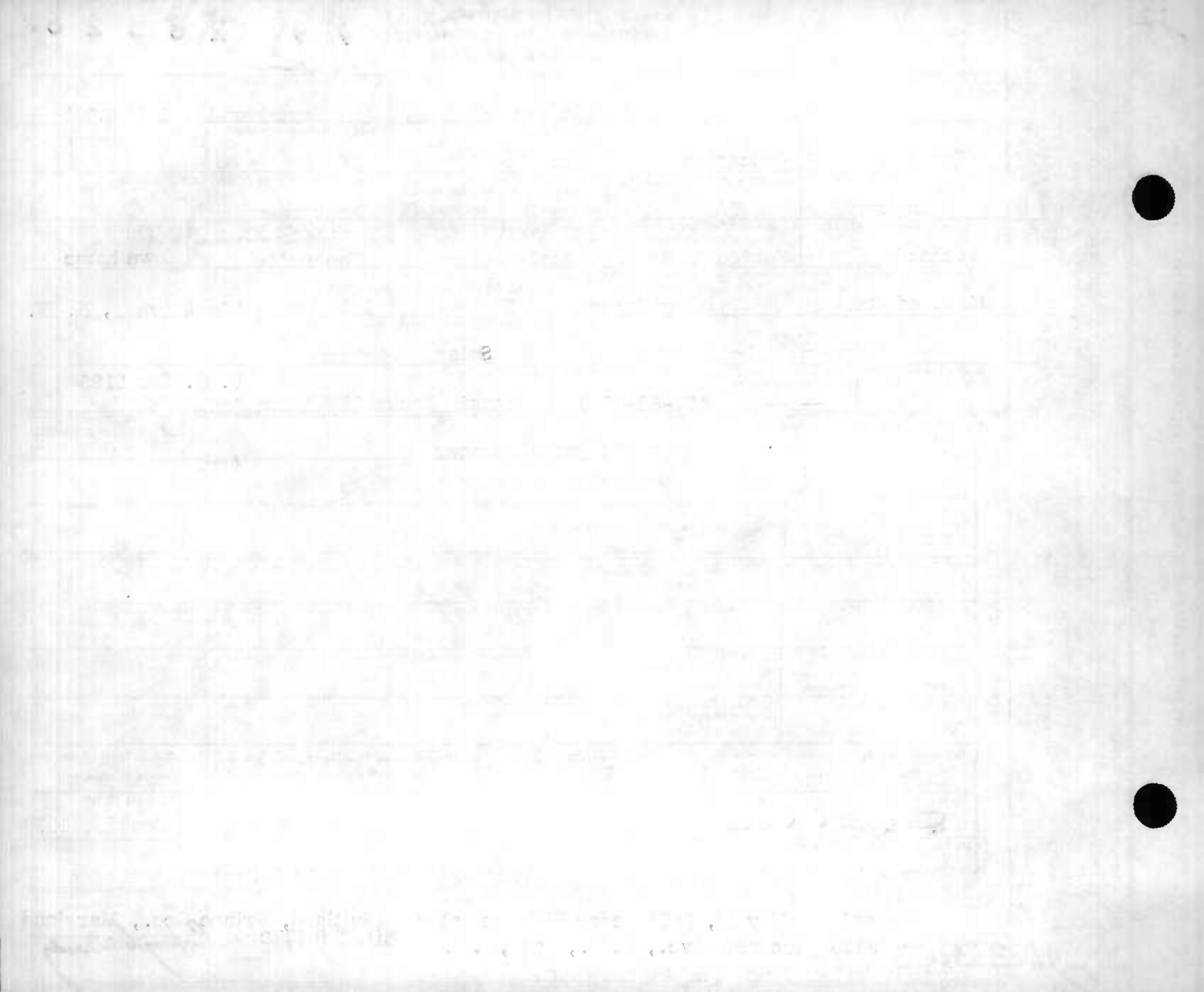
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 8 5 2 6	
1 - FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn D. Riheldaffer			2a DATE OF DEATH MONTH DAY YEAR November 10, 1979		2b HOUR 0204a M
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Dec 26, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) England	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a STATE Dist. of Col		13b COUNTY Washington	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 2828 Connecticut Ave N. W.	
14 FATHER'S NAME FIRST MIDDLE LAST Unknown Degenhardt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 577-58-0809		17 INFORMANT ADDRESS P. O. Box 2125	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Cancer</u> 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>Nov 02</u> 19 <u>79</u> to <u>Nov. 10</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov 10</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>George T. Gamblin</i>		DEGREE		22c DATE SIGNED Nov 13, 1979	
22d PHYSICIAN'S NAME (TYPE OR PRINT) George T. Gamblin, M.D.		22e ADDRESS National Naval Medical Center, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE Nov 16, 1979	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Geo., Maryland	
24 FUNERAL DIRECTOR NAME Joseph Gawler Sons		24b ADDRESS 5130 Wisconsin Ave. N. W., Wash, D. C.		25a DATE OF REGISTRATION NOV 20 1979	
25b REGISTRAR SIGNATURE <i>Joseph Gawler Sons</i>		25c REGISTRAR NAME Washington D. C.			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

28527

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Marion S Roberts</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>11 24 79</u>		2b. HOUR <u>8:40</u> P. M.	
3. SEX <u>F</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>05 03 13</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>SOUTH DAKOTA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.	
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>U.S. GOVERNMENT</u>	
13a. STATE <u>MARYLAND</u>				13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>SILVER SPRING</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>JOHN SHARDA</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ETHEL LARSON</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>332-05-5518</u>		17. INFORMANT <u>SON</u>		ADDRESS <u>10 HUMPHREY TERR. SWAMPSCOTT, MASS.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF THE PANCREAS</u> WEEDS. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ABDOMINAL CARCINOMATOSIS</u> WEEDS. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>NOV. 1</u> 19 <u>79</u> to <u>NOV. 24</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>NOV. 24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death.							
23a. SIGNATURE (TYPE OR PRINT) <u>ALBERT H. GROLCHAN MD</u>				DEGREE <u>MD</u>		23b. DATE SIGNED <u>11/24/79</u>	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALBERT H. GROLCHAN MD</u>				23d. ADDRESS <u>1106 S. 11th ST. SILVER SPRING, MD.</u>			
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23f. DATE <u>11/29/79</u>		23g. NAME OF CEMETERY OR CREMATORY <u>EDGEHILL CEMETERY</u>		23h. LOCATION CITY OR TOWN COUNTY STATE <u>WEST NANTICOKE PA.</u>	
24. FUNERAL DIRECTOR'S NAME <u>FRANCIS J. COLLINS</u>				25. DATE REC'D. BY REGISTRAR <u>NOV 27 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony McQuady</u>	
26. ADDRESS <u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>							

UNITED STATES

NEW YORK, N. Y.

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

IN THE OFFICE OF THE ATTORNEY GENERAL

NEW YORK, N. Y.

STATE

DEPT. OF JUSTICE

OFFICE

RECEIVED

IN THE OFFICE OF THE ATTORNEY GENERAL

NEW YORK, N. Y.

RECEIVED

IN THE OFFICE OF THE ATTORNEY GENERAL

NEW YORK, N. Y.

DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Oneida Roberts								November 6, '79		9 <sup>05</sup> AM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		Oct. 6 1922		57 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Tenn.		U.S.A.				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital						Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Montgomery		Wash. Grove		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		104 Maple Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Wiley J. Roberts				Sarah Roberts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		-		218-52-8441		Joe Franklin Roberts		104 Maple Ave., Washington Grove, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 6256 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory arrest</u> DOE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
Oct 31, 79		Stress incontinence		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22. I certify that (I) (the hospital) attended the deceased from <u>Oct 31</u> 19 <u>79</u> , to <u>Nov 6</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov 6</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
Edward C. Gilbert		M.D.						Nov 6, 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Edward C. Gilbert, M.D.				15 E. Deerpark, Gaithersburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Nov. 9, '79		Laytonsville Cemetery		Laytonsville		Montg.,		Md.	
24. FUNERAL DIRECTOR		316 E. Diamond Ave.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Gartner-Sandison F. H.		Gaithersburg, Md.		NOV 13 1979		Dorothy McBrady					



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST PHILIP			MIDDLE A. H.			LAST ROBERTS			2b. DATE KNOWN OF DEATH MONTH DAY YEAR 11 23 1979			2c. HOUR M 11						
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 4, 1913		6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 23 1979			2d. HOUR M 5:31						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) vidalia, Louisanna				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.									
10. CITY OR TOWN OF DEATH Silver Sprg.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired U. S. government.				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland												13b. COUNTY Pr. George		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4615 Powder Mill Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Wayne W. Roberts.												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vivian Hough.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes.				16b. SOCIAL SECURITY NO. 427-46-8461				17. INFORMANT ADDRESS M. Margaret E. Roberts. (13 e).													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic lung cancer DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) Assistant		DATE SIGNED 11-24-79	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 27-1979		23c. NAME OF CEMETERY OR CREMATORY Admission		23d. LOCATION CITY OR TOWN Baltimore		23e. STATE MD	
24. FUNERAL DIRECTOR (NAME) John V. Vetter		24b. DATE Nov 27-1979		24c. REGISTRAR'S SIGNATURE 254 Carroll St. NO					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lillie V. Robinson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 6, 1979</b>		2b. HOUR 4:20 A M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 16 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Suitland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5702 Norman Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. McQuay</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Shank</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-01-3317</b>		17. INFORMANT ADDRESS <b>Same as Above</b> <b>Beatrice R. Lowery, Daughter</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>396-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bacterial Endocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Myocardial and Aortic Valve Disease</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>6 weeks</b> <b>ancient</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary Artery Disease</b>									
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/9</b> 19 <b>79</b> , to <b>11/5</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/5</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Daniel J. Boyle M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-20-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel J. Boyle M.D.</b>				22e. ADDRESS <b>5103 Marlboro Pike Hillside Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reliance Mem. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reliance, Warren, Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Robt E Wilhelm</b>				ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 09 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

2102 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT WITH PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28531	
1. FOR STATE REGISTRAR						7. DATE KNOWN OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) WILLIAM ROBINSON JR.						2. DATE KNOWN OF DEATH MONTH 11 DAY 15 YEAR 1979					
3. SEX M		4. RACE B		5. DATE OF BIRTH NOV 29 1924		6. AGE (IN YEARS) 54 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
7c. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR			
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12b. KIND OF BUSINESS OR INDUSTRY GOVT			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS 809 LARCH AVE					
13a. STATE MD		13b. COUNTY mont		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 809 LARCH AVE			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM M. ROBINSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE R. FIELDS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW EE 579209111		17. INFORMANT BETTY J. ROBINSON				ADDRESS 809 LARCH AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> 411- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John E. Ball				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED Nov 15, 1979			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE NOV 21, 1979		23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM VETERAN				23d. LOCATION CHELTENHAM, MD COUNTY STATE	
24. FUNERAL DIRECTOR ALEXANDER S. POBE 2617 PENNSYLVANIA AVE S.E.						25a. DATE REC'D BY REGISTRAR NOV 26 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



WILLIAM H. HALL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
7 9 2 8 5 3 2									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Emma A. Rogers</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>11-20-79</i>		2b. HOUR MIN <i>5:45 PM</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 13 1887</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>91</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D. C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Takoma Park,</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House Wife.</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland.</i>						13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Silver Spring.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles A. Wayson.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie O'Riley.</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>8615 Piney Br. Rd. S. s.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>579-12-0596</i>		17. INFORMANT ADDRESS <i>Dorsey Rogers. ( Husband ) 13 e</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/28</i> 19 <i>79</i> to <i>11/20</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>11/20</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Patricia K. Stagg</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>11/20/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Patricia K. Stagg</i>						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 24, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY. <i>Cedar Hill.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland Pk. P. George Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Arthur Walters</i>						25a. DATE REC'D. BY REGISTRAR <i>NOV 27 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia K. Stagg</i>	



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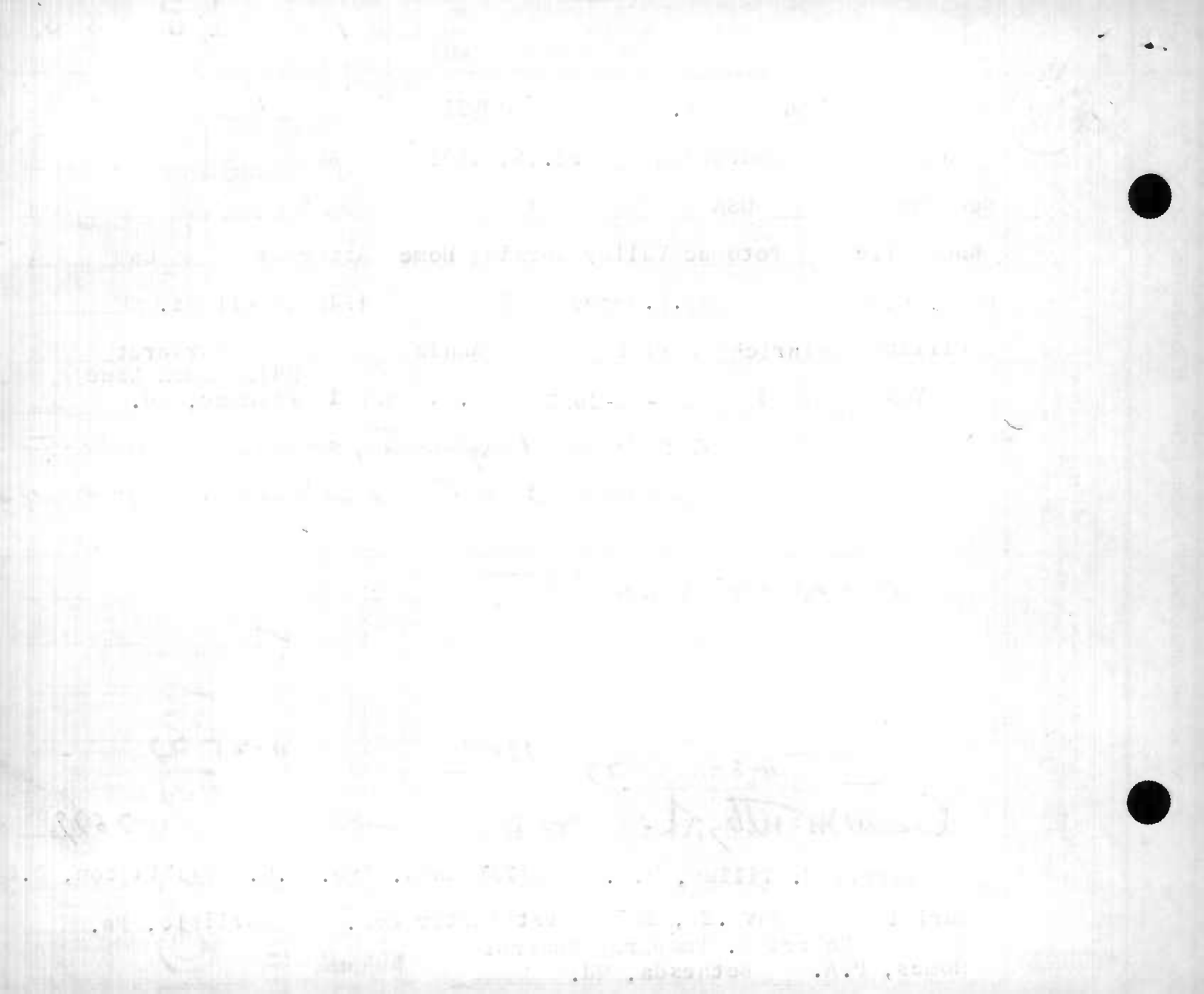
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 5 3 3							
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR				
			ROYAL		R.		ROMMEL		11 25 79		8:20 <sup>PM</sup>						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			Caucasian			Dec. 26, 1892			86 YRS.			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
New York			USA						Montgomery MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville			Potomac Valley Nursing Home									Attorney		Law			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
			D. C.						Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4546 Lowell St. NW		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
William Heinrich Rommel						Annie Ehrhardt											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT								
Yes						WW I			579-52-2697 John M. Rommel Potomac, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) cardio-respiratory arrest												minutes					
4409																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
(b) generalized arterio sclerosis												years					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
Progressive senility																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK								STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from 1968 19 to 11-25-79, that (I) (we) lost saw the deceased alive on 11-8-79 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																	
22b. SIGNATURE								DEGREE		22c. DATE SIGNED							
Russell M. Tilley, M.D.								MD		11-26-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS									
Russell M. Tilley, M.D.								4701 Mass. Ave. N.W. Washington, D.C.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN		COUNTY STATE					
Burial				Nov. 29, 1979		Westminster Cem.				Carlisle, Pa.							
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.								NOV 30 1979									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eduvigis C. ROSARIO				2a. DATE OF DEATH MONTH DAY YEAR November 27 1979			2b. HOUR 3:16 P.M.		
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR April 20 1917		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Puerto Rico Catano						13c. CITY OR TOWN Levittown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS G-27 Magda East	
14 FATHER'S NAME FIRST MIDDLE LAST Not Available						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO N7A		17 INFORMANT ADDRESS Jose Rosario Lorenzana See item 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aortic Valve Replacement</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic Stenosis NYHA Class IV</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 17</u> , 19 <u>79</u> , to <u>Nov. 27</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>J. E. Schwartz</i>				DEGREE				22c. DATE SIGNED Nov. 27, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. E. Schwartz				22e. ADDRESS National Naval Medical Center Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12-1-79		23c. NAME OF CEMETERY OR CREMATORY Puerto Rico National		23d. LOCATION CITY OR TOWN COUNTY STATE Bayamon P.R.					
24 FUNERAL DIRECTOR NAME ADDRESS Metropolitan Funeral Service Alexandria, Va.				25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

Not Available

Not Available

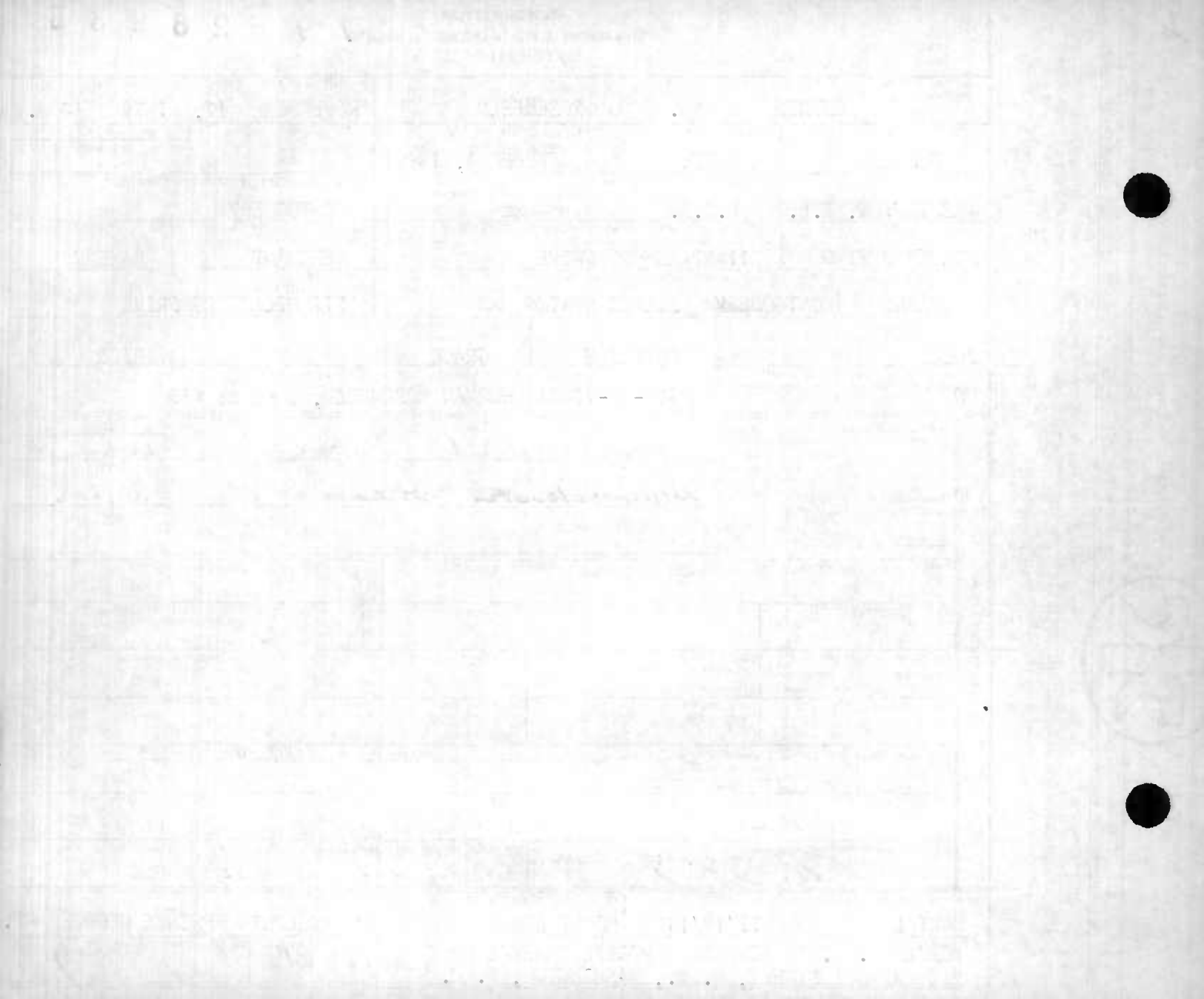
NA

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 8 5 3 5
1- FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>ESTHER G. ROSENFELD</b>					2a DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 17, 1979</b>			2b HOUR <b>10 A.M.</b>		
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 3, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>711 HILLSBORO DRIVE</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>711 HILLSBORO DRIVE</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>JULES GOTTLIEB</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GRACE RICE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-56-1193A</b>		17 INFORMANT ADDRESS <b>HERMAN ROSENFELD, same as #13</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerotic Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>10 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <b>1976</b> to <b>17 Nov</b> , 19 <b>79</b> , that (1)(we) last saw the deceased alive on <b>Oct</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1)(we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Lewis Kellart</b> MD DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/17/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis Kellart</b>					22e. ADDRESS <b>1811 Prince Phillip Dr, Olney, Md. 20832</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/19/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ADELPHI PRINCE GEORGES MD.</b>				
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SALI ROSENFELD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 22, 1979</b>		2b. HOUR <b>536 P M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 25, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Management</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Warehouse</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8484 16th Street, #510</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herman Rosenfeld</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Stern</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-07-5160</b>			17. INFORMANT <b>Herman Rosenfeld</b> ADDRESS <b>11512 Bedfordshire Ave. Potomac, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> <b>4409</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>hypertension</b> (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11-22-79</b> to <b>11-22-79</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>11-22-79</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <b>Robert Kramer</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			19. DATE SIGNED <b>11/23/79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT KRAMER</b>			22e. ADDRESS <b>8630 Fenton Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/25/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Lebanon Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi, Prince George's, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Donald M. Stein</b>			ADDRESS <b>232 Carroll Street, N. W. Washington, D. C.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28537	
1. DECEASED NAME (TYPE OR PRINT) <b>Jeane Susan Paul Savary</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>11-23-79</b>		2b. HOUR <b>12:15</b>		2c. DATE PRONOUNCED DEAD <b>Nov 23 1979</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 18 06 73</b>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN <b>73 YRS.</b>		7c. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7d. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>France</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Tak. Park</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Architect Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>						13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leopold Savary</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Copen</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>579-58-2841</b>		17. INFORMANT <b>Irma Savary</b> wife ADDRESS <b>same as 13c</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4291</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>Dep.</b>				DATE SIGNED <b>Nov 23 1979</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 26, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>							
500 University Blvd., W. Silver Spring, Md.											

11-23-73 12:13

Severy

Time

10:00

Time

12:13

Washington Adolescent Hospital

Admission

Room

Ward

Room

Admission

100-100000-100000

100-100000-100000

No

1917 Southern Bell Silver Spring, Md.

John S. Rogers, M.D.

Nov. 24, 1973 State of Maryland

Francis J. Chubb

500 Independence Blvd., Silver Spring, Md.

MED EXAMINER - DR BALL - APPROVED

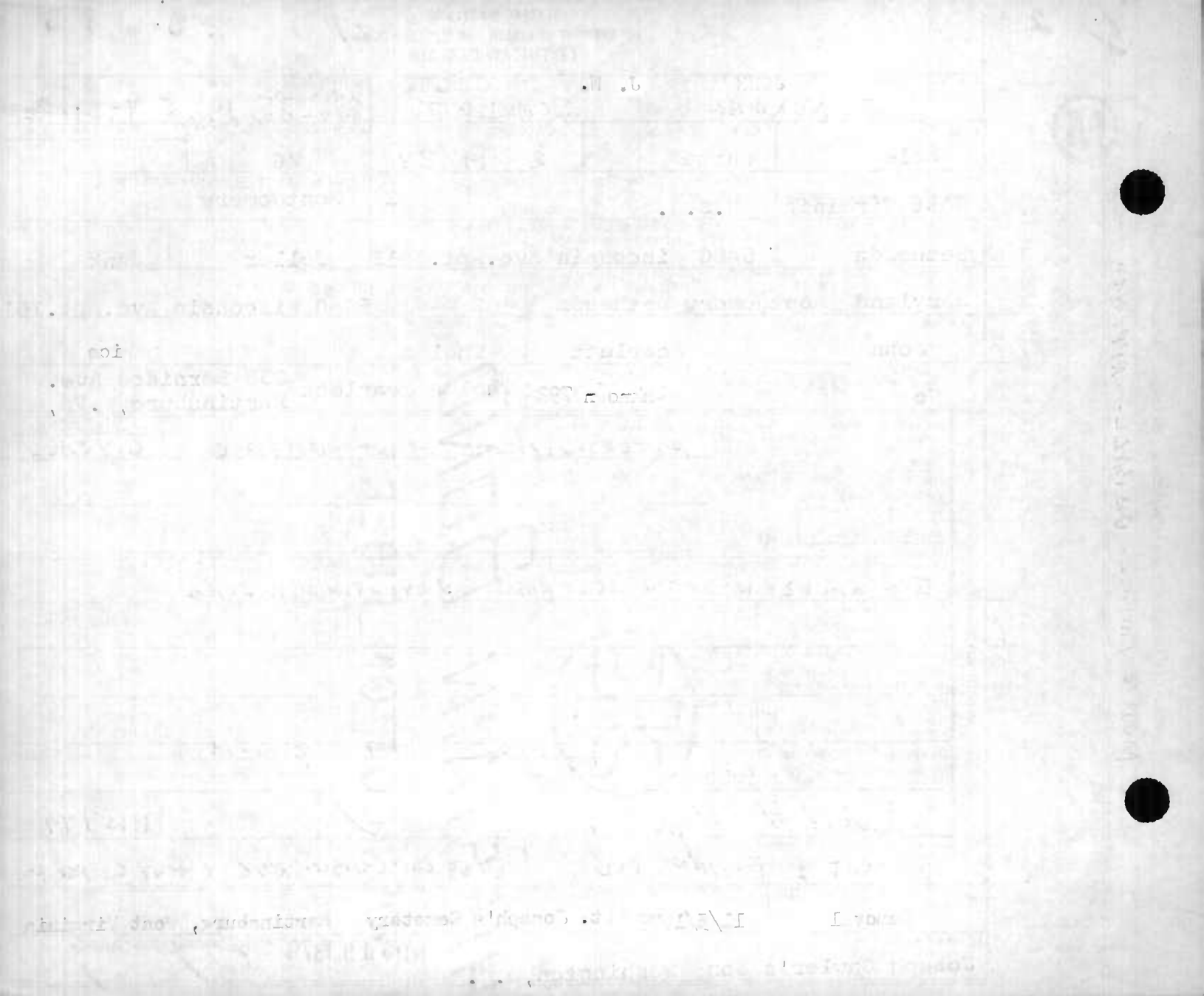
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pay attention to the instructions on the reverse side of this certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

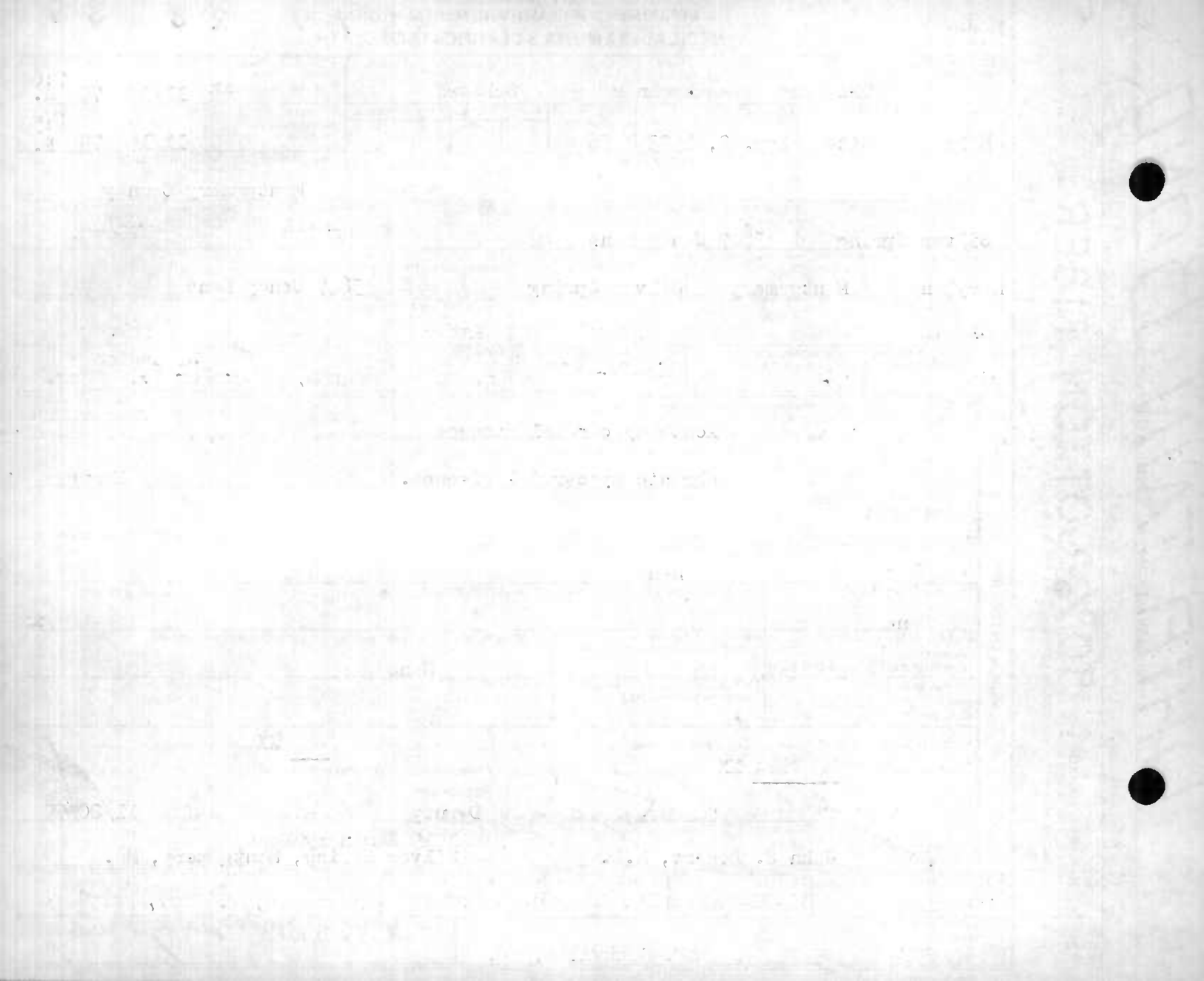
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <b>JOHN N. SCARLETT</b> <b>J. NORMAN SCARLETT</b>				2b. DATE OF DEATH MONTH DAY YEAR <b>11 5 79</b>		2c. HOUR <b>11:45 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 19 33</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5480 Wisconsin Ave. Apt. 1613</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teller</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Montgomery</b> 13d. CITY OR TOWN <b>Bethesda</b>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>5480 Wisconsin Ave. Apt. 1613</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Scarlett</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Thelma Rice</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>232-46-3792</b>		17. INFORMANT <b>Thelma Scarlett</b>		17a. ADDRESS <b>238 Berniece Ave. Martinsburg, W. Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>6 YEARS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIO-SCLEROSIS, POLYCYTHEMIA VERM</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> , 19 <b>77</b> , to <b>present</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert L Flynn M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/5/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. FLYNN, M.D.</b>		22e. ADDRESS <b>5454 WISCONSIN AVE CITYVIEW CIRCLE Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/5/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Martinsburg, West Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Washington, D.C.</b>		ADDRESS		25a. DATE REG'D. BY REGISTRAR <b>NOV 09 1979</b>		25b. REGISTRAR'S SIGNATURE			



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3A. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				7 2 8 5 3 9									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR A. M. P. M.			
Theodore		Frohner		Schaerf				11/19/79		7:00		A. M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	
Male		White		Sep. 2, 1923		56 YRS.						11/19/79		4:50 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Austria		USA				Montgomery County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring		3807 Wendy Lane		Economist		USGovt.									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Montgomery		Silver Spring						3807 Wendy Lane					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Samuel		Schaerf		Esther		Frohner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		N/A		119-24-1539		Dr. Tully Benaron, 9 Burnham Rd. Mass.		W. Newton							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
None															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) Deputy MEDICAL EXAMINER		DATE SIGNED 11/20/79											
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.		1919 Seminary Road Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Cremation		11-18-79		Ft. Lincoln Crematory		Brentwood, P. Geo., Maryland									
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.		NOV 26 1979		[Signature]											





## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28540	
1. DECEASED NAME (TYPE OR PRINT) <b>Louis Frederick Schmadebeck</b>						2a. DATE KNOWN OF DEATH <b>11-15-79</b>		2b. HOUR <b>11:35AM</b>		2c. DATE PRONOUNCED DEAD <b>11-15-79 11:35A</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2-29-12</b>		6. AGE (IN YEARS) <b>67</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Mont.</b>	
10. CITY OR TOWN OF DEATH <b>Tak Park</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>	
13a. STATE <b>MD</b>						13b. CITY OR TOWN <b>College Park</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>354 Marlborough Way</b>	
14. FATHER'S NAME <b>Henry Schmadebeck</b>				15. MOTHER'S MAIDEN NAME <b>Annie Young</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT <b>Marie Schmadebeck (Wife)</b>				17. ADDRESS <b>Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>Dep</b>				DATE SIGNED <b>Nov 15 1979</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. John S. Rogers</b>				ADDRESS <b>Silver Spring, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beaver Dam, Dodge Co., Wisconsin</b>			
24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home</b>				ADDRESS <b>Riverdale, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry H. H. H.</b>	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28541	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Noel Yousif Shammas</b>								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 17 1979</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 - 22-1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>62</b>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11 17 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iraq</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Iraq</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Government official</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Iraq</b>		13b. COUNTY <b>Baghdad</b>		13c. CITY OR TOWN <b>Baghdad</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Yousif Shammas</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bedour Marmardjy</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <b>Brother Jacob Yousif Shammas</b>				ADDRESS <b>460 Beaumont Ave. Pacific Grove, CA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. BODY ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>11/18/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>11/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baghdad Iraq</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 Univ. Blvd., W., Silver Springs, MD 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>		25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

Page 10

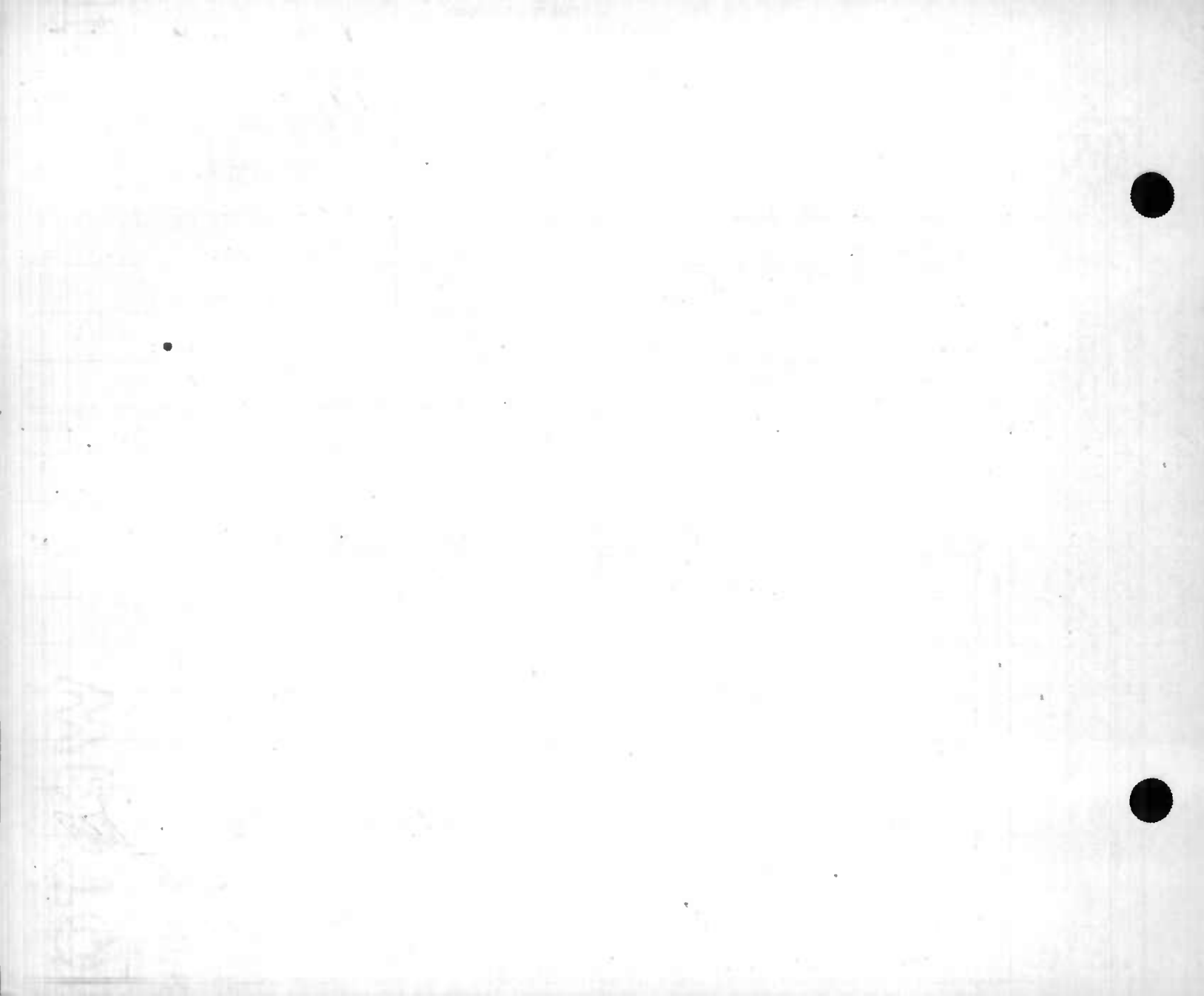
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 5 4 2 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>MARQUERITE MAC SHEFFRAY</b>				2a DATE OF DEATH MONTH DAY YEAR <b>10/1/79</b>				2b HOUR <b>8:35</b> # M			
3 SEX <b>F</b>		4 RACE <b>W.C.</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8/22/96</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bel Pre Health Care Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Admin. Assist.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>US Government</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>				13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Rockville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>16206 Sycamore Lane</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frank MacSheffray</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Wallace</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>579-60-5587</b>		17 INFORMANT ADDRESS <b>8320 Morningside Drive</b> <b>Andy Hongell, Manassas, Virginia 22110</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic heart disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 days</b> <b>4 yrs</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>chronic osteomyelitis of left hip</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22 I certify that (I) (this hospital) attended the deceased from <b>2/21</b> 19 <b>74</b> to <b>1/1</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/1</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>R.T. Benack MD</b>				DEGREE <b>MD</b>				22c DATE SIGNED <b>11/1/79</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.T. Benack MD</b>				22e ADDRESS <b>4115 Colie Dr. Wheaton, Md</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>11-05-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G.Co., Maryland</b>					
24 FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home, Inc.</b>				25a DATE REC'D. BY REGISTRAR <b>NOV 07 1979</b>				25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			
11800 New Hampshire Ave., Silver Spring, Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST <i>Herbert Earl Shepard</i>					MONTH DAY YEAR <i>11-5-79</i>					<i>1:35 a.m.</i>	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
MALE		WHITE		MONTH DAY YEAR <i>JULY 18, 1911</i>			68		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS.		
NORTH CAROLINA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTGOMERY		HOURS MIN.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL					OWNER		LIQUOR STORE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8912 MAPLE AVE. P.O. Box 81			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST <i>RANSOM SHEPARD</i>				FIRST MIDDLE LAST <i>CATHERINE JAMES</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				579 03 3861		Theda R. Shepard Same as #13 (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Transitional Cell Carcinoma</i>										Years	
1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>Sept</i> 19 <i>79</i> to <i>November 5</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>11/4</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Byrl D. Johnson</i>					DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/5/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BYRL D. JOHNSON MD</i>					22e. ADDRESS <i>4404 Queensbury Rd. Riverdale, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			11/7/79		Cedar Hill Cemetery			Suitland P.G. Md.			
24. FUNERAL DIRECTOR'S NAME <i>Francis Gasch's Sons Funeral Home, P.A.</i>						24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Hyattsville, Maryland						NOV 08 1979		<i>Harry M. Bury</i>			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17  
(VR A15 ME) (J)  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 28544		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stanley Gilmore Sheppard								2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 11 8 1979		7b. HOUR M 8:30A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 5 1952	6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 8 1979		2d. HOUR M 8:30A				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bethesda		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital (D.O.A.)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk & Repairman		12b. KIND OF BUSINESS OR INDUSTRY Jewelry				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md.	13b. CITY OR TOWN Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3 Tifton Ct., Potomac, Md.								
14. FATHER'S NAME FIRST MIDDLE LAST Willard E. Sheppard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mariam Lorraine Sheppard								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-64-2379		17. INFORMANT ADDRESS 3 Tifton Ct., Potomac, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? PM 11 8 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in car on street		21f. LOCATION CITY OR TOWN COUNTY STATE Rt. 495 & Connecticut Ave, Bethesda, Mont, MD.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 11/9/79				
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/11/79		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montgomery Md.				
24. FUNERAL DIRECTOR Rosebell Sandison				316 E. Diamond Avenue, Gartner-Sandison F.H. Gaithersburg, Md.				25a. DATE REC'D. BY REGISTRAR NOV 13 1979		25b. REGISTRAR'S SIGNATURE		



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Item 18b G539 1/18/80 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

7 9

2 8 5 4 5

1 - STATE  
REGISTRAR

## CERTIFICATE OF DEATH

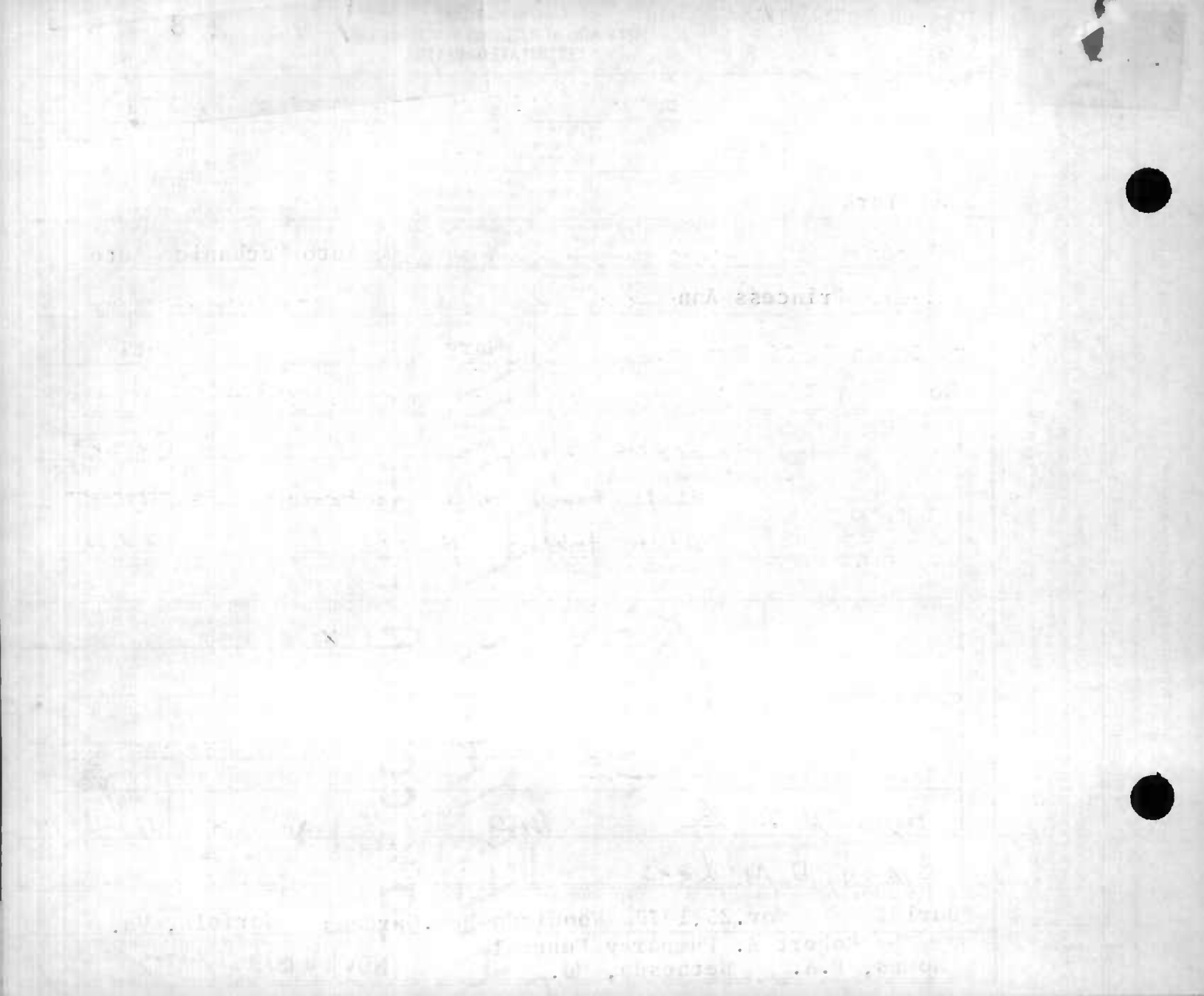
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Joseph Sibley Jr			2a. DATE OF DEATH MONTH DAY YEAR November 23, 1979		2b. HOUR A M 6:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 2, 1956		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a. STATE Virginia			13b. COUNTY Princess Anne	13c. CITY OR TOWN Virginia Beach	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Mr. James J. Sibley Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Monti		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 231-86-4897		17. INFORMANT ADDRESS Mrs. James J. Sibley (Same as Above)	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock 2040 DUE TO, OR AS A CONSEQUENCE OF (b) acute lymphocytic leukemia DUE TO, OR AS A CONSEQUENCE OF (c) acute tubular Necrosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 5 months 9 years 2 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) this hospital attended the deceased from October 15, 1979, to November 23, 1979, that (X) (we) lost saw the deceased alive on November 23, 1979, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.					
22b. SIGNATURE Byron D. McLees		DEGREE MD		22c. DATE SIGNED 11/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Byron D. McLees		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 25, 1979	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Norfolk, Va.
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.			25a. DATE REC'D. BY REGISTRAR NOV 29 1979		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.97  
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Rosalia Siodotti</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 15 79</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 5 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>59</b>		7b. HOUR <b>3:55 A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13f. STREET ADDRESS <b>Md. P.G. Hyattsville YES NO 5002 55th Ave.</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dominic Ziehino</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Incoronata Deleo</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Unkn.</b>		16b. SOCIAL SECURITY NO. <b>577-58-4120</b>		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recent Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure, diabetic mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>11/7</b> , 19 <b>79</b> , to <b>11/14</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Antonio G. Uy</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/15/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO G. UY MD</b>				22e. ADDRESS <b>831 Univ. Blvd E #15 Silver Spring, Md 20903</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>11/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCuskey</b>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		NOVEMBER		7, 1979	
MARGERY		DELANEY		SMITH						1:30 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR		32 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Louisiana		U.S.A.		MARCH 27, 1947		MONTGOMERY COUNTY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		NIH CLINICAL CENTER, BETHESDA, MD		Housewife		Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. CITY OR TOWN		13c. STREET ADDRESS					
GEORGIA				Warner Robinson		304 UTAH DRIVE				31093	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Billey Walter		Doris								Dobbins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		254-80-0611		MR. MICHAEL F. SMITH		304 UTAH DRIVE W.R., Ga.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY:		(1) Cardiopulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4275 IMMEDIATE CAUSE (a) (2) Widely Metastatic Melanoma											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF									
		DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <u>NOVEMBER 7, 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death.		22b. SIGNATURE Robert E. Hall		DEGREE MD		22c. DATE SIGNED 11-7-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Hall		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Nov. 9, 1979		Glen Haven Cemetery Macon, Bibb Co., Ga.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Pearson's Funeral Home F., C., Va.		NOV 13 1979		Robert E. Hall							



(1) Cardiology  
(2) Medical History

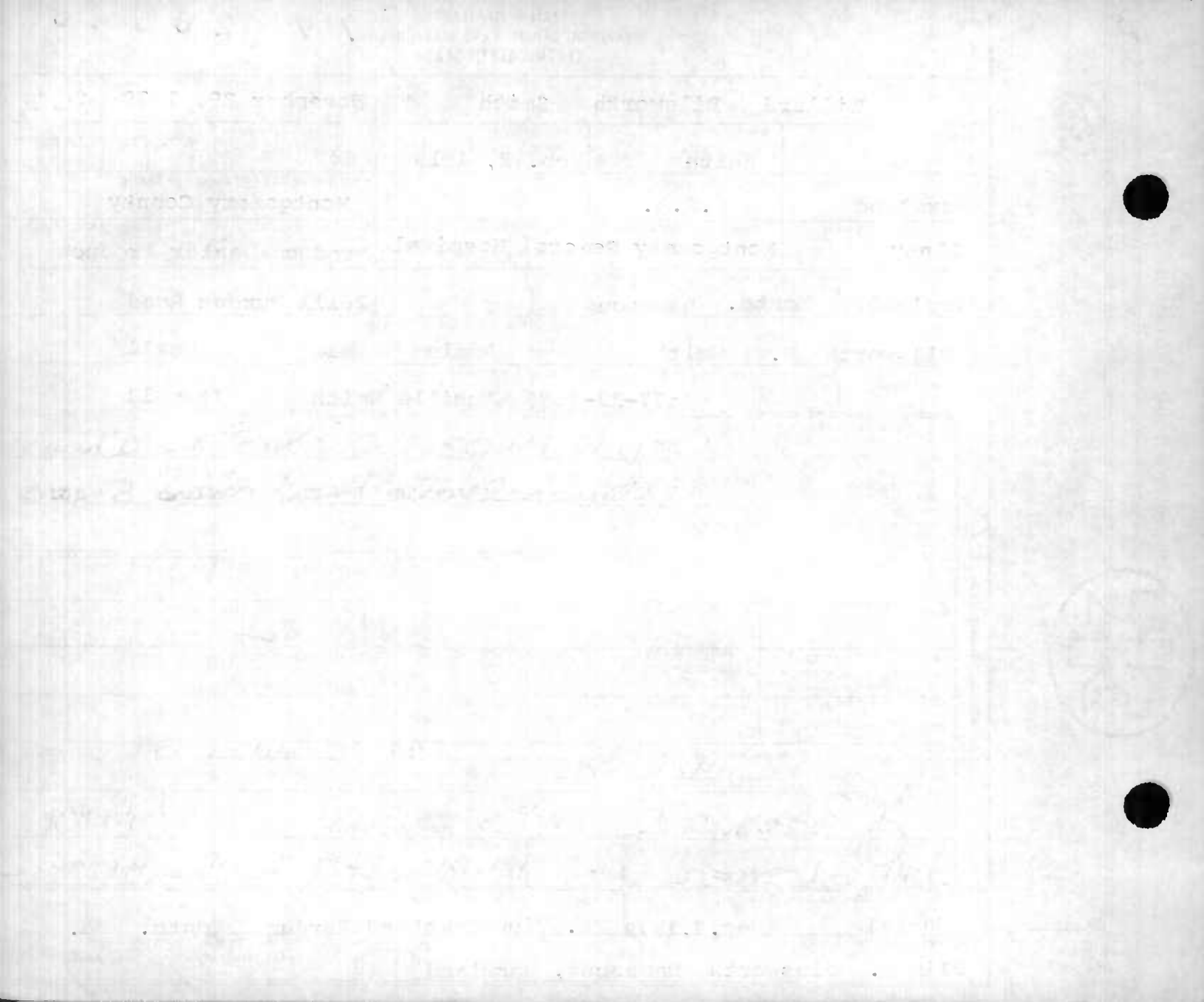
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Willard Ellsworth Smith						2a. DATE OF DEATH MONTH DAY YEAR November 29, 1979		2b. HOUR 8:27 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Produce Dealer		12b. KIND OF BUSINESS OR INDUSTRY Produce	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 26111 Purdum Road	
14. FATHER'S NAME FIRST MIDDLE LAST Ellsworth M. Smith					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Mae Beall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-22-4080		17. INFORMANT ADDRESS Lucille Smith Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sugar</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> , 19 <u>79</u> , to <u>11/29</u> , 19 <u>79</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>11/29</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.									
22b. SIGNATURE <u>[Signature]</u> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 11/29/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMELL MD				22e. ADDRESS 1811 Prince Dr. A. Olney, Md 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 3, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Purdum Montg. Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth				ADDRESS Damascus, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 3 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

0200



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ralph William Snoots			2a. DATE OF DEATH MONTH DAY YEAR November 30, 1979			2b. HOUR P 2:08 M				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 16, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver		12b. KIND OF BUSINESS OR INDUSTRY Montg. Co. Roads Dept.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Snoots					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unavailable) Shoemaker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223-18-4112		17. INFORMANT ADDRESS Mary Katherine Snoots, Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest (History)</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Coronary Thrombosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15' 2 hrs 24 hrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>It has old ulcer history + Cor. ASD. E puri m t</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>5/5/79</u> 19 <u>79</u> to <u>11/30/79</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>11/14/79</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Stephen N. Jones</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/3/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones				22e. ADDRESS 809 Viers Mill Rd. Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-4-79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial pk		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland				
24. FUNERAL DIRECTOR NAME P. A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Monte. Co.  
Horse Butte

Frank Oliver

U. S. A.

Virginia

Oliver

Shoemaker

(unavailable)

Shoemaker

Charles

Box 18-11112 New Katherine Shoemaker, Box 18

No

George H. Jones

12-4-70 Serial

URGENT: PRIORITY MESSAGE NO. 10  
Knoxville, Tennessee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR			REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST Eva			MIDDLE R.			LAST STACK			2a. DATE OF DEATH MONTH DAY YEAR November 26 1979			2b. HOUR 1:47P M				
3 SEX Female			4 RACE Caucasian			5 DATE OF BIRTH MONTH DAY YEAR Oct. 8 1898			6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			7a. IF UNDER 1 YEAR MONTHS DAYS			7b. IF UNDER 24 HRS. HOURS MIN				
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee			7d. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.										
10 CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4450 South Park Ave. Apt. 1713	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Reynolds					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tennie Fly					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 579-12-1861				
17. INFORMANT Mrs. Bonnie Lie bschner										ADDRESS Warrington, PA 83 Wood Ridge Dr.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency secondary to metastatic carcinoma of the breast DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from Nov. 16, 1979, to Nov. 26, 1979, that (I) (we) last saw the deceased alive on Nov. 26, 1979, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Douglas E. Jacobsen MD					DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED Nov. 27, 1979									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas E. JACOBSEN, M.D.					22e. ADDRESS National Naval Medical Center, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/29/1979		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.											
24. FUNERAL DIRECTOR NAME Jos. Gawler Sons					ADDRESS Washington, D. C.					25a. DATE REC'D BY REGISTRAR DEC 3 1979					25b. REGISTRAR'S SIGNATURE [Signature]				

0 2 2 2 1 1 1

1201-54-012

11/25/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mabel Gertrude Stansbury</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>11 13 79</b>		2b. HOUR <b>4:46AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN 13e. STREET ADDRESS <b>Maryland Baltimore Catonsville 117 N. Symington Avenue</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Allen</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Wheatley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-76-0639</b>		17. INFORMANT ADDRESS <b>Mr. Richard A. Stansbury Mt. Airy, 16708 Frederick</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Digitalis Toxicity.</b>											
19a. DATE OF OPERATION <b>11/12/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>COMPLETE HEART BLOCK</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>November 12, 1979</b> to <b>November 13, 1979</b> , that (I) (we) lost the deceased alive on <b>November 12, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Barry Hecht</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/13/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY HECHT</b>				22e. ADDRESS <b>10620 GEORGETA AVE SILVER SPRING</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Md.</b>					
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>				ADDRESS <b>Catonsville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barry Hecht</b>			



10/10/50

Clayton

10/10/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

7 9 2 8 5 5 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>PLON</b> <b>STOTLER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11 25 79</b>			2b HOUR <b>234</b> M			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 25 1885</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Retirement &amp; Nursing Cen</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b KIND OF BUSINESS OR INDUSTRY <b>arage</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>D.C.</b>			13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Washington</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Richland Stotler</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Spielman</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>578-01-1021</b>		17 INFORMANT <b>Wife</b> ADDRESS <b>Sada Stotler, 5126 Cathedral Ave., Wash. D.C.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4409 Pulmonary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sensitivity</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Dysphagia Bilateral pharyngeal &amp; Keels</b>									
19a DATE OF OPERATION <b>—</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— — — 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>10-8-79</b> 19 <b>79</b> , to <b>Nov-25</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>P. J. Andrews</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>11-25-79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. J. ANDREWS</b>				22e ADDRESS <b>4977 BATTERY LA. Bethesda Md</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>11/27/1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc</b>				ADDRESS <b>5130 Wisc Ave., N.W.</b>		25a DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY M. STURTEVANT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 5, 1979</b>			2b. HOUR <b>8 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 25, 1912</b>		6. AGE [IN YEARS LAST BIRTHDAY] <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9712 Old Spring Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maritime Comm.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9712 Old Spring Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Moore</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Klopfer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-62-3804</b>		17. INFORMANT ADDRESS <b>William B. Sturtevant Same as Item # 13</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MALIGNANT LYMPHOMA.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>		
								<b>1 WEEK.</b>		
								<b>5 1/2 YEARS</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HEPATIC INSUFFICIENCY.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>6-30-</b> 19 <b>74</b> to <b>11/1/</b> 19 <b>79</b> , that <del>the</del> (we) last saw the deceased alive on <b>11-1-</b> 19 <b>79</b> , and that in (my) <del>their</del> opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (we) <del>did</del> (did not) view the body after death.										
22b. SIGNATURE <b>Robert J. Jacobson</b> M.B. BCh.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>11/6/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert J. Jacobson</b>					22e. ADDRESS <b>3800 Reservoir Rd., N.W., Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md. Prince Georges Co.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Henry McHenry</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

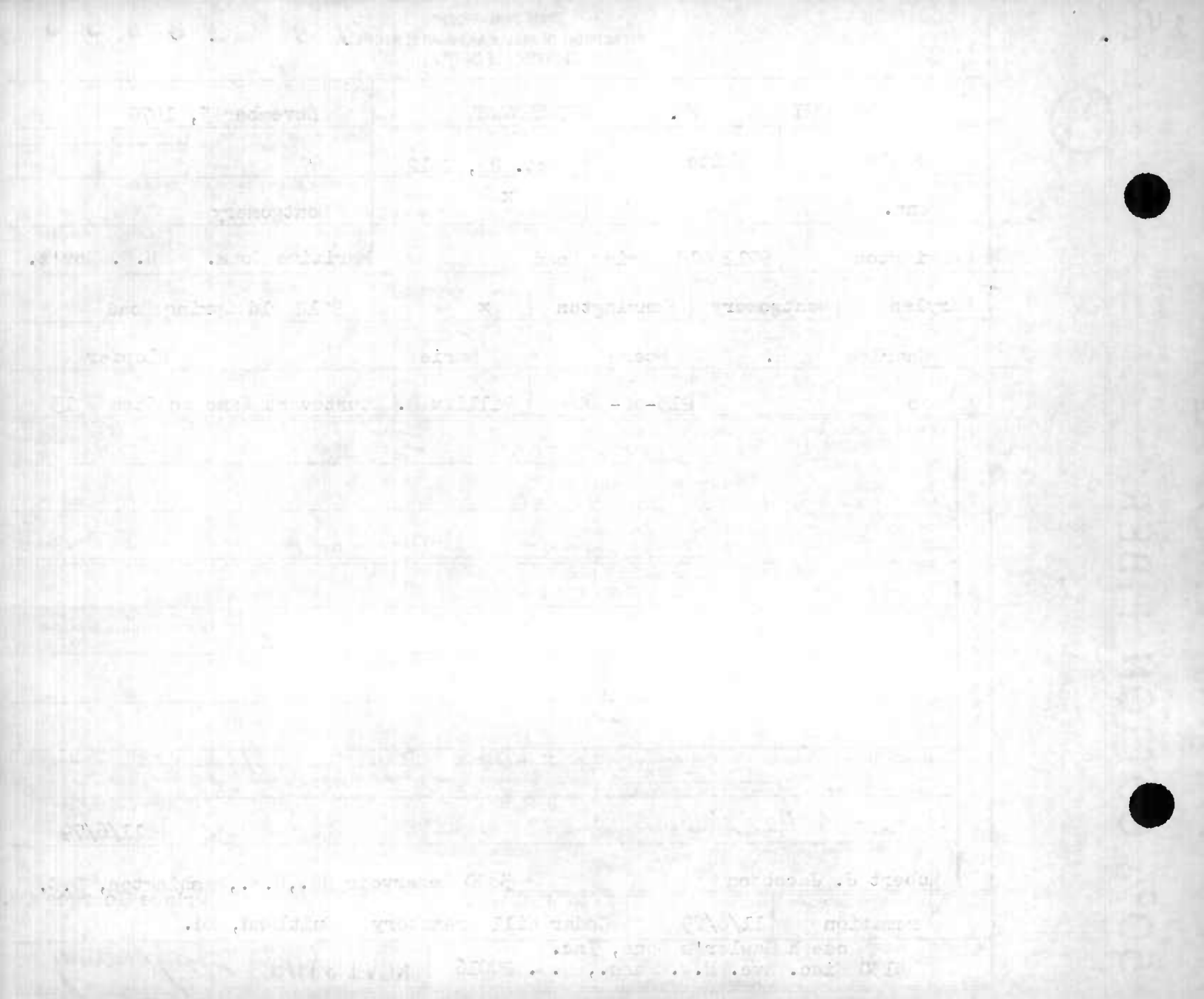
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

4100 BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE																			
1. FOR STATE REGISTRAR					7 9 2 8 5 5 4 CERTIFICATE OF DEATH														
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH														
Luth Taylor					Nov. 17, 1979														
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR											
Fem		Black		Jan 25 1903		76 YRS.		M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.											
N. C.		USA				Mont													
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY											
Whitaker		University Nursing Home				Housewife		None											
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCY BEFORE ADMISSION)					15. INSIDE CITY LIMITS?					16. STREET ADDRESS									
13a. STATE					13b. COUNTY					13c. CITY OR TOWN									
D. C.					Washington					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
Bryant Whitfield					Virginia Foushee														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS									
NO					Unk.					Margaret T. McCauley/daughter/same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1979, to Nov. 6, 1979, that (I) (we) lost saw the deceased alive on 11/6/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																			
22b. SIGNATURE Myron L. Berkau										22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial					11-21-79					Lincoln Memorial					Suitland, Md.				
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
John T. Rhines Co., 3015 12th St., N.E., D.C.										NOV 26 1979					Morton McCauley				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Richard B Thibadeau				11 28 79 9:42 PM			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		CAUCASIAN		FEB. 14 1887		92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
GEORGIA		U.S.A.				Montgomery MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		PHYSICIAN		PVT. PRACTICE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13510 DEAKINS LANE	
MD. MONTGOMERY GERMANTOWN							
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
JOSEPH HARNEY THIBADEAU				MINA JO MALONEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
NO						LENA D. THIBADEAU (SAME AS 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5070 Codropsymonary arrest							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
Aspirational pneumonia and							
DUE TO, OR AS A CONSEQUENCE OF							
Congestive heart failure							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
Diasternal ulcer disease, renal insufficiency failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
11/24/79		Suspected appendicitis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 11/24/79 to 11/28/79, that (1) (we) lost saw the deceased alive on 11/28/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
H. Robert Birschbach, M.D.						11/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
H. Robert Birschbach, M.D.				10401 Old Georgetown Rd. Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		12-1-79		GATE OF HEAVEN CEM.		SILVER SPRING MONTG. MD.	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY FUNERAL HOMES P/A		MD.		DEC 6 1979		Robert B. Birschbach	

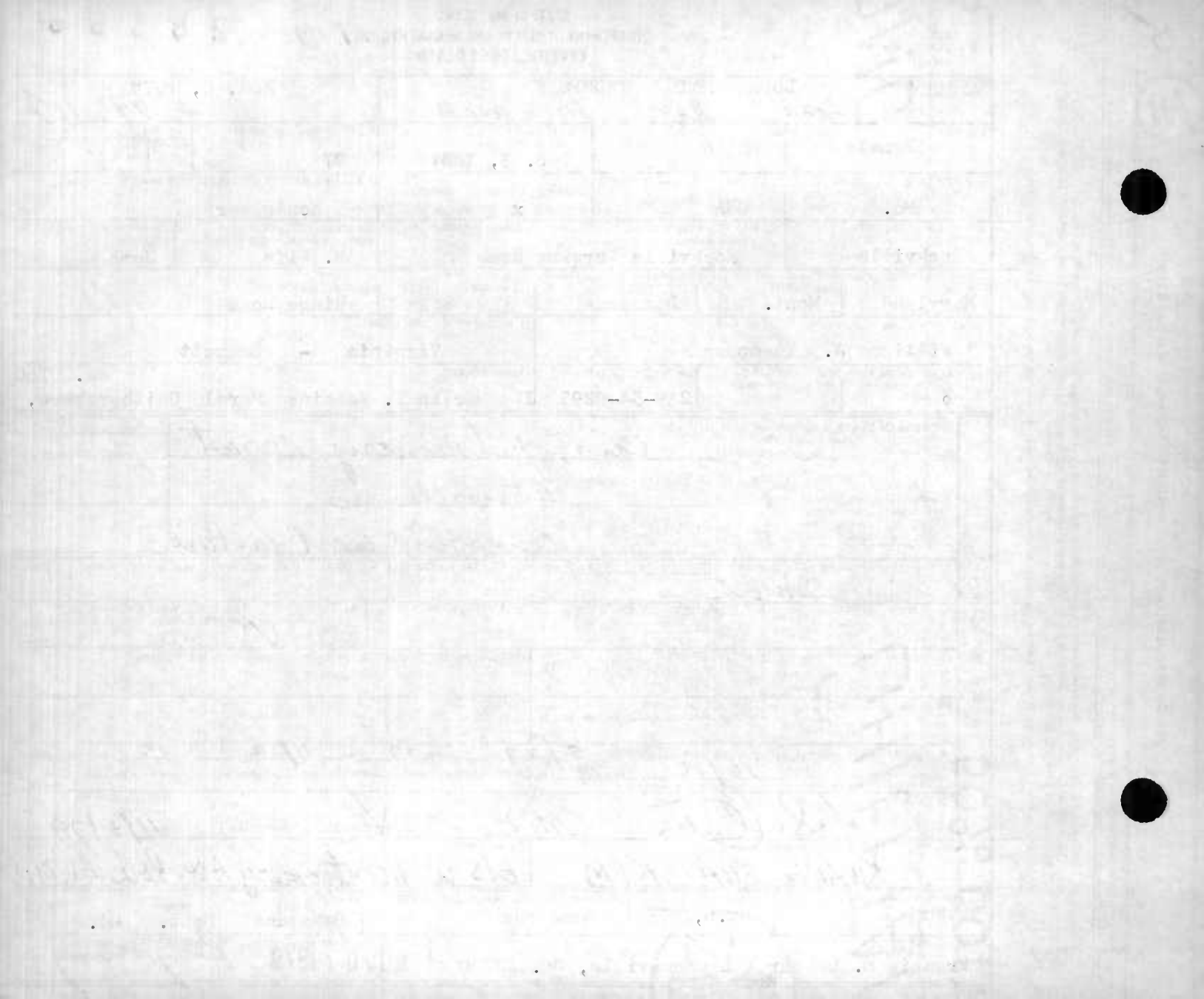


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Lola MAY Thompson</b>					2a. DATE OF DEATH MONTH <b>NOV.</b> DAY <b>2,</b> YEAR <b>1979</b>				
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>Dec. 3,</b> DAY <b>1881</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.		7b. HOUR <b>11 50 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rockville Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H. Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Damascus</b>		13e. STREET ADDRESS <b>Ridge Road</b>			
14. FATHER'S NAME FIRST <b>William J.</b> MIDDLE <b>Thompson</b> LAST					15. MOTHER'S MAIDEN NAME FIRST <b>Virginia</b> MIDDLE <b>Bennett</b> LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>219-54-9293</b>		17. INFORMANT ADDRESS <b>Md. 20760</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Senility</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/27</b> , 19 <b>77</b> , to <b>11/3</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>10/15</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>K. S. Suh</b> DEGREE <b>M.D.</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KWANG SUH KIM</b>					22e. ADDRESS <b>615 W. Montgomery Ave. Rockville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SP) <b>Burial</b>		23b. DATE <b>Nov. 6, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Damascus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Damascus Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md. 20760</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 07 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 8 5 5 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TILLIE TRAGER			2a. DATE OF DEATH MONTH DAY YEAR 11-23-79		2b. HOUR 7:50 A.M.
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 28, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6801 Wilson Lane	
14 FATHER'S NAME FIRST MIDDLE LAST Morris Weirnik		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Gertrude (unknown)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17 INFORMANT ADDRESS Leon Trager, 6801 Wilson Ln., Bethesda, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for Part I. (If more than one cause, list on separate lines.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5163 Pulmonary Failure DUE TO OR AS A CONSEQUENCE OF (b) Progressive Pulmonary Fibrosis 6 years DUE TO, OR AS A CONSEQUENCE OF (c) Hemiparesis - Right Hemiparesis 6 years.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/25/79 to 11/23/79, that (I) (we) lost saw the deceased alive on 11/23/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.					
22b. SIGNATURE J. Blaine Fitzgerald		DEGREE MD		22c. DATE SIGNED 11/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald		22e. ADDRESS 8218 Wisconsin Ave. Bethesda.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-25-79	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24 FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.			25a. DATE REC'D. BY REGISTRAR NOV 28 1979	25b. REGISTRAR'S SIGNATURE L. J. McCreedy	

BP



1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in all financial dealings.

2. The second part of the document outlines the specific procedures for recording and reporting transactions. It details the steps involved in the accounting process, from initial recording to final reporting.

3. The third part of the document discusses the importance of regular audits and reviews. It explains how these processes help to ensure the accuracy and integrity of the financial records.

4. The fourth part of the document provides information on the various roles and responsibilities of the accounting staff. It describes the tasks of each position and how they contribute to the overall financial management of the organization.

5. The fifth part of the document discusses the importance of maintaining up-to-date financial information. It explains how this information is used to make informed decisions and to plan for the future.

6. The sixth part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in all financial dealings.

7. The seventh part of the document outlines the specific procedures for recording and reporting transactions. It details the steps involved in the accounting process, from initial recording to final reporting.

8. The eighth part of the document discusses the importance of regular audits and reviews. It explains how these processes help to ensure the accuracy and integrity of the financial records.

9. The ninth part of the document provides information on the various roles and responsibilities of the accounting staff. It describes the tasks of each position and how they contribute to the overall financial management of the organization.

10. The tenth part of the document discusses the importance of maintaining up-to-date financial information. It explains how this information is used to make informed decisions and to plan for the future.



DHMH - 17  
(VR A15 ME (5))  
15M 7/76

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						7 9 2 8 5 5 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John A. Trauth, Jr.						2a. DATE KNOWN OF DEATH ESTI- MATED 11 25 1979			2b. HOUR 9 30 A M		
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1919		6. AGE (IN YEARS) LAST BIRTHDAY 60 RS.		7c. DATE PRONOUNCED DEAD Nov. 25 1979		2d. HOUR 9 30 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Poolesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16321 Morrow Dr.				12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Swimming Pool Contractor & Acct.			12b. KIND OF BUSINESS OR INDUSTRY Self		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY Montg.		13c. CITY OR TOWN Poolesville			
14. FATHER'S NAME FIRST MIDDLE LAST John A. Trauth, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Craven					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Dorothy I. Trauth		17. ADDRESS Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute - 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) Chronic Pulmonary obstructive Disease - DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Marked Obesity											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 11-27-79			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS Bethesda, Md. 7916 Old Georgetown Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov. 29, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg, Md.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.				ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR NOV 30 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

Date: 10/10/1919

Location: Louisville, KY

Person: J. M. Morrow

Address: 1011 10th St.

Phone: 1011 10th St.

Notes: 1011 10th St.

10-17-19  
This Old Georgetown

John C. Hall

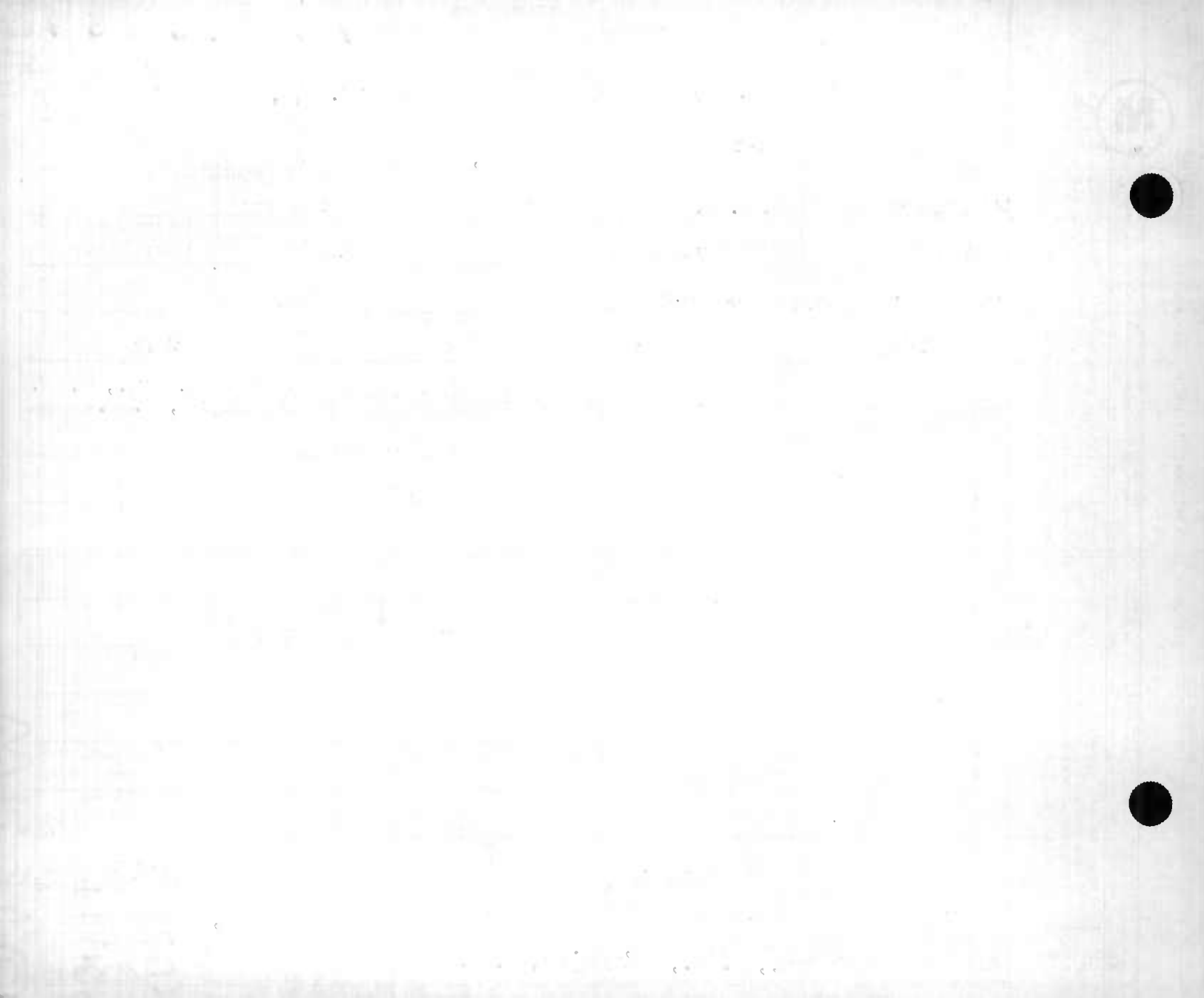
10-17-19  
Robert A. Kennedy  
1011 10th St.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 5 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>CATHARINE HUGHES TUNNEY</b>			2a. DATE OF DEATH MONTH <b>NOV.</b> DAY <b>18,</b> YEAR <b>1979</b>			2b. HOUR <b>5:35 P.M.</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>25,</b> YEAR <b>1896</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		7. IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5101 River Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Bethesda</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5101 River Road</b>			
14 FATHER'S NAME FIRST <b>Patrik</b> MIDDLE <b></b> LAST <b>Hughes</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b></b> LAST <b>Keller</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>184-44-2759</b>		17 INFORMANT <b>Catharine Nicolaides</b>				ADDRESS <b>5900 Conn. Ave., N. W. Washington, D. C.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4249</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Valvular Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION <b>29</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>November 11, 1979</b> , to <b>November 18, 1979</b> , that (I) (we) last saw the deceased alive on <b>November 16, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Clifton R. Gruver MD</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CLIFTON R GRUVER</b>						22e. ADDRESS <b>1145-19 ST. N.W. WASH. D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>11-21-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Sepulchre Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Philadelphia,</b> COUNTY <b>Pennsylvania</b> STATE <b></b>			
24 FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisconsin Ave., N. W., Washington, D. C.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McBrady</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be not filed at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 6 0

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARSHAL SWANSON TURNER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11/29/79</b>			2b HOUR <b>8:15 P M</b>				
3 SEX <b>MALE</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10/21/13</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD				
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GSA</b>		12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
13a STATE <b>Md.</b>			13b COUNTY <b>Montg.</b>		13c CITY OR TOWN <b>Bethesda</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>4611 Steaford Rd.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Walter V. Turner</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Addie Glascock</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 246-18-5787A</b>		17 INFORMANT <b>Myra H. Turner</b>			ADDRESS <b>Same as 13</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>1970</b> , 19 <b>Nov 29</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 29, 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
27b. SIGNATURE <b>DeWitt E. DeLauster MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <b>11-29-79</b>		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DeWitt E. DeLauster MD</b>			27e. ADDRESS <b>5500 Friendship Blvd Chevy Chase Md 20015</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 3, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Md</b>			
24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 5 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>				

100-100000

100-100000

AGE

Montgomery

USA

Virginia

U.S. Gov't.

CSA

Richards

1011 Stenford Rd.

X

Richards

Monte

Id.

Clascock

Addie

Turner

V.

Walter

2mo as 15

Wm H. Turner

246-18-2787A

Wm H

Yes

100-100000

100-100000

Dec 3, 1970 Date of Death

Initial

Robert A. Humphrey Funeral

Homes, R.A. Richards, Id.

Silver Spring, Md.

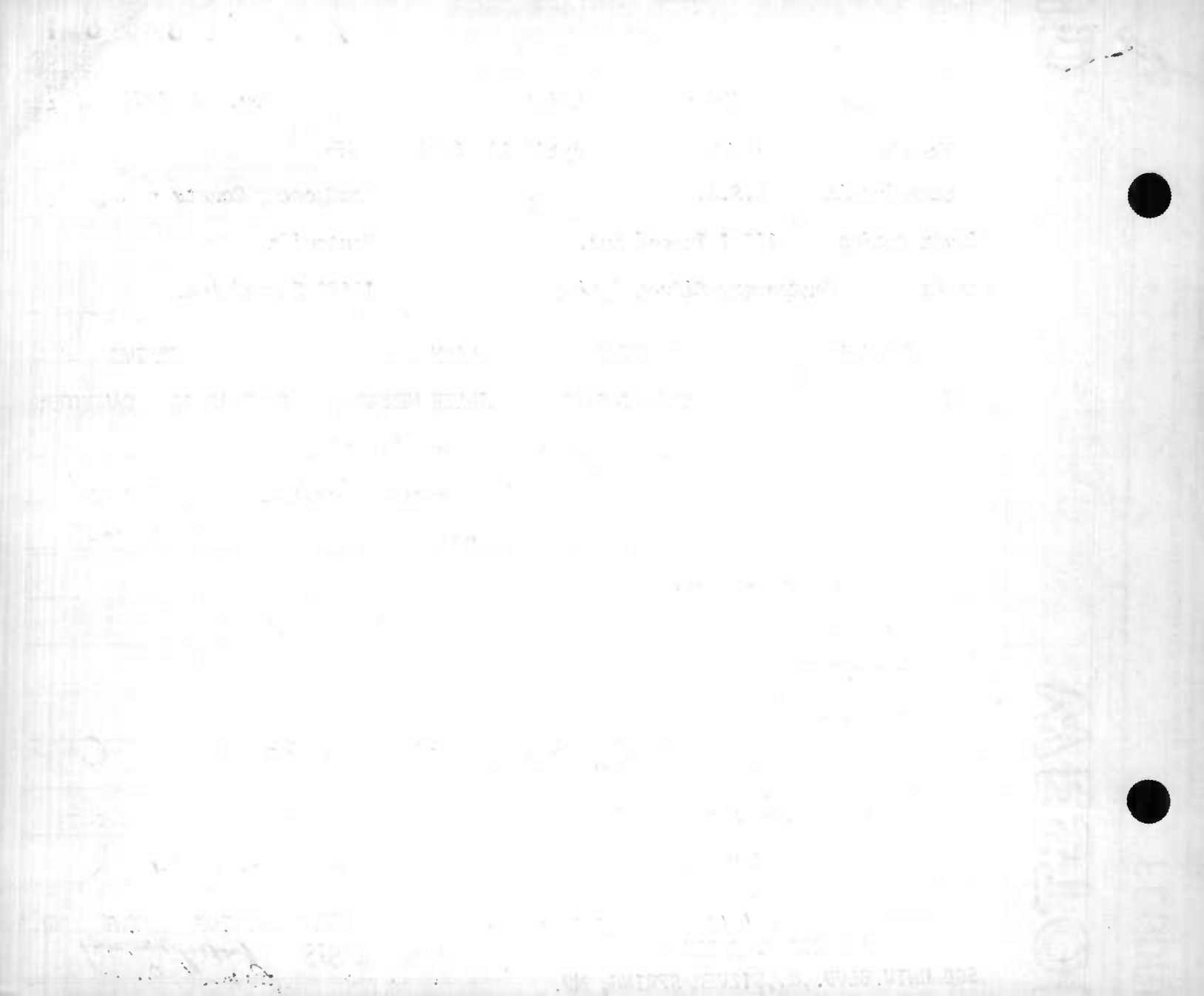
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
REG. NO. 7 9 2 8 5 6 1									
1. DECEASED NAME (TYPE OR PRINT) Anna Mary Ugiss					2a. DATE OF DEATH Nov. 4 1979		2b. HOUR 4 A.M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH April 19, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 85 80		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 11901 Inwood Ave.				12a. USUAL OCCUPATION Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Montgomery		13c. STREET ADDRESS Silver Spring		
14. FATHER'S NAME STANLEY GARKOSKY					15. MOTHER'S MAIDEN NAME MARY PERKINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 208-42-5823		17. INFORMANT JULIE MERGEN SAME AS 13 DAUGHTER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulm Arrest 4280 DUE TO, OR AS A CONSEQUENCE OF (b) Asphyxia-Cardiac 3-4 mos DUE TO, OR AS A CONSEQUENCE OF (c) CHF 6+ mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): irregular heartbeats									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 79 to present 19 79, that (I) (we) lost saw the deceased above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. H. Sandstrom MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-5-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. H. Sandstrom MD				22e. ADDRESS 7701 Caron Ave Takoma Park, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/6/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD.				25. DATE REC'D. BY REGISTRAR NOV 8 1979		25b. REGISTRAR'S SIGNATURE [Signature]			





FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 2 8 5 6 2

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Howard Joseph Underwood</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11 23 79</b>			2b HOUR <b>5:30AM</b>		
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 25 1906</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10 CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hosp., Olney Md.</b>				12a USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) <b>GPO</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>				13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Silver Spring</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Richard T. Underwood</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth McCORMICK</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17 INFORMANT <b>wife</b> <b>Emily E. Underwood</b> same as 13c				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (the hospital) attended the deceased from <b>November 22, 1979</b> , to <b>November 23, 1979</b> , that (I) <del>last</del> saw the deceased alive on <b>November 22, 1979</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>would</del> (did not) view the body after death.								
22b. SIGNATURE <b>Barry Hecht</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Barry I. Hecht</b>				22e. ADDRESS <b>10620 Ga. Ave., Silver Spring, Md. 20906</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 26, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Mont. Md.</b>		
24. FUNERAL DIRECTOR'S NAME <b>Francis J. Collins</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1979</b>				
500 University Blvd., W. Silver Spring, Md.								

25

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1

Clerical Medical Examiner

2

9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200 University Road, N. Silver Spring, Md.  
Francis J. Collins  
Nov. 24, 1970 Date of Review

Silver Spring, Mont.

Dr. Francis J. Collins, 200 University Road, N. Silver Spring, Md.

Yes      10/11      114-4-9143      Emily E. Underwood      same as 114

Richard      T.      Underwood      John      Elizabeth      November 1970

Montgomery      Silver Spring      15114      Elizabeth      Rock

114-4-9143      114-4-9143      114-4-9143      114-4-9143      114-4-9143

USA      114-4-9143

114-4-9143      114-4-9143      114-4-9143      114-4-9143      114-4-9143

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

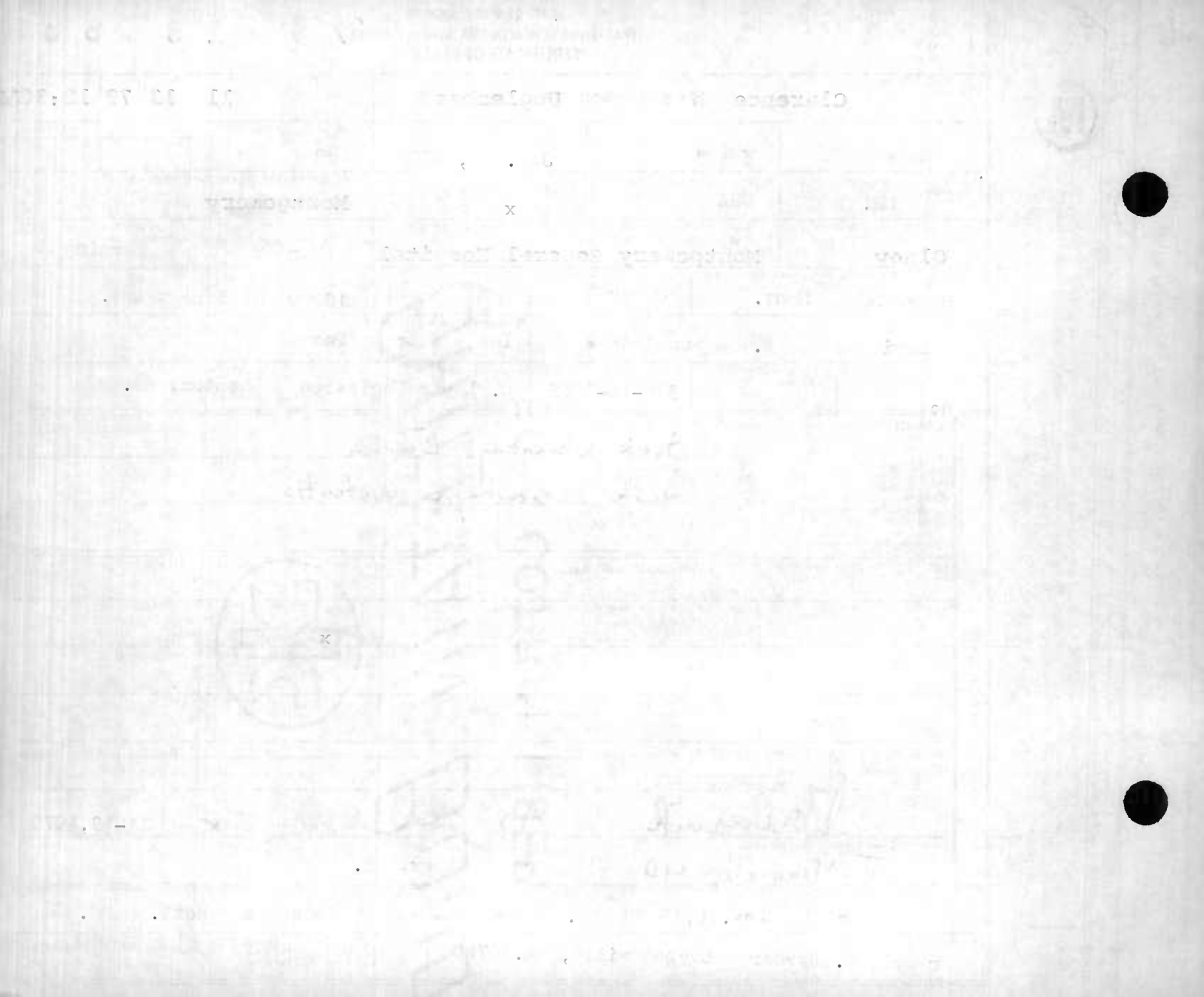
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Clarence Washington Unglesbee</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>13</b> YEAR <b>79</b>			2b. HOUR <b>12:30AM</b>			
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>27</b> YEAR <b>1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b> DAYS <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>18200 Hillcrest Ave.</b>	
14. FATHER'S NAME FIRST <b>Lewis</b> MIDDLE <b>E.</b> LAST <b>Unglesbee</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Kate</b> LAST <b>Fox</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>579-16-3365</b>		17. INFORMANT ADDRESS <b>C. Lewis Unglesbee Wheaton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary Edema</b> 5350 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Acute hemorrhagic gastritis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. Minarcik</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-13, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Minarcik, MD</b>						22e. ADDRESS <b>Olney, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Nov. 16, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		23d. LOCATION CITY OR TOWN <b>Sunshine</b> COUNTY <b>Mont.</b> STATE <b>Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md. 20760</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1979</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

1  
9

1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 6 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>HERBERT L Uppercue</b>			2a DATE OF DEATH MONTH <b>11</b> DAY <b>23</b> YEAR <b>79</b>			2b HOUR <b>9:15</b> M				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>9</b> DAY <b>27</b> YEAR <b>04</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY County, MD.</b>				
10 CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Wash. Terminal</b>		
13a STATE <b>Maryland</b>			13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Silver Spring</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Frederick</b> LAST <b>Uppercue</b>			15 MOTHER'S MAIDEN NAME FIRST <b>Miriam</b> MIDDLE <b>E.</b> LAST <b>Morgan</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b SOCIAL SECURITY NO <b>719-16-3738A</b>			17 INFORMANT ADDRESS <b>316 Hillmoor Dr.</b> <b>Marguerite Uppercue Silver Spring, Md.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 CARDIORESPIRATORY Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Refractory Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> Approximate Interval Between Onset and Death <b>1 Hour</b> <b>2 weeks</b> <b>4 years</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <b>Emphysema, Diabetes</b>										
19a DATE OF OPERATION <b>August 19 79</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetes</b>			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>August 19 79</b> to <b>Nov 23 79</b> , that (I) (we) lost saw the deceased alive on <b>11/23/79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>John A. Galotto</b>			22c ADDRESS <b>5225 Pook Hill Rd Bethesda, Md. 20814</b>			22d DATE SIGNED <b>11/23/79</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>Nov. 27, 1979</b>			23c NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24 FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b> ADDRESS <b>11800 New Hampshire Ave. Silver Spring, Md.</b>						25a DATE REC'D. BY REGISTRAR <b>NOV 29 1979</b> 25b REGISTRAR'S SIGNATURE <b>John A. Galotto</b>				

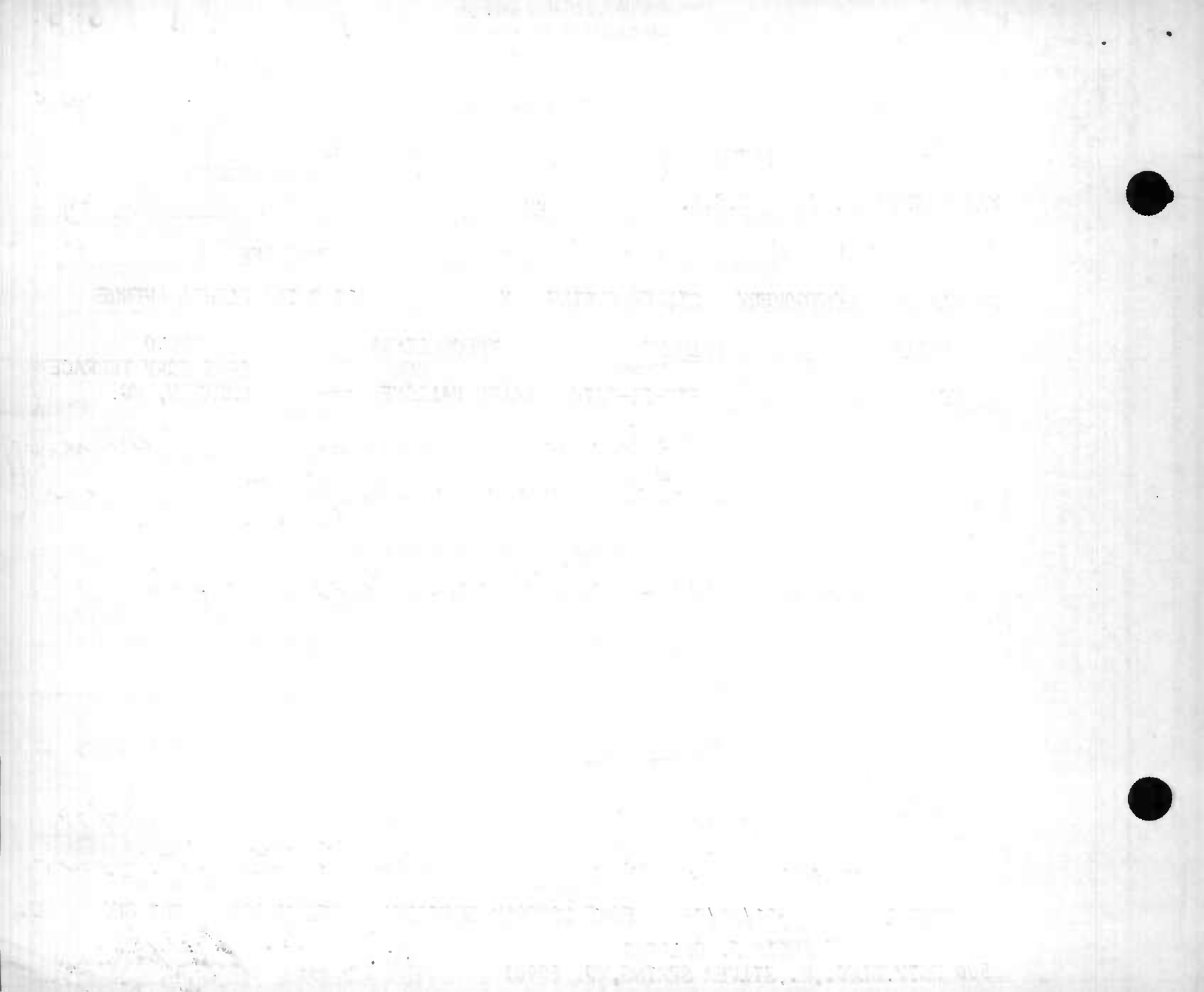
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Annie M Vallone		MONTH DAY YEAR 11 17 79	
3. SEX		2b. HOUR	
7		7:19 A.M.	
4. RACE		5. DATE OF BIRTH	
WHITE		MONTH DAY YEAR 5 20 09	
6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
70		MONTHS DAYS	
8. IF UNDER 24 HRS		9. BALTIMORE CITY OR COUNTY OF DEATH	
HOURS MIN		Montgomery County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
WASHINGTON, D. C.		U.S.A.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Silver Spring		Holy Cross Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HOUSEWIFE			
13a. STATE		13b. COUNTY	
MARYLAND		MONTGOMERY	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		15. MOTHER'S MAIDEN NAME	
874 PHILADELPHIA AVENUE		THEODOLINDA BUONO	
14. FATHER'S NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
EMILIO		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT	
577-32-3674		SON	
17. ADDRESS		2645 CORY TERRACE WHEATON, MD.	
18. RALPH VALLONE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>		40 min.	
4140 DUE TO, OR AS A CONSEQUENCE OF		years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>Severe arteriosclerotic heart disease</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Severe chronic obstructive lung disease</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. INJURY OCCURRED		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> 19 <u>79</u> , to <u>11/17</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> 19 <u>79</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
<u>Barry N. Rosenbaum, M.D.</u>		11/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
BARRY N. ROSENBAUM		3720 FARRAGUT AVE. KENSINGTON, MD. 20795	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		11/20/79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
FORT LINCOLN CEMETERY		BRENTWOOD PRI GEO MD.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
FRANCIS J. COLLINS		NOV 19 1979	
500 UNITV. BLVD., W., SILVER SPRING, MD. 20901		25b. REGISTRAR'S SIGNATURE <u>Barry N. Rosenbaum</u>	



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Emmett G. Vaughn</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>8</b> YEAR <b>79</b>			2b. HOUR <b>5:25</b> P.M.				
3. SEX <b>MALE</b>		4. RACE <b>COLORED</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>3</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TK. PARK MD.</b> Mont MD.				
10. CITY OR TOWN OF DEATH <b>MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>					13b. COUNTY <b>S. SPRING</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>VAUGHN</b> LAST					15. MOTHER'S MAIDEN NAME FIRST <b>SARA</b> MIDDLE <b>JANE</b> LAST <b>WEAVER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-18-9372</b>		17. INFORMANT ADDRESS <b>MAMIE VAUGHN (WIFE) 106 SCHUYLAR RD.</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopospietory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Squamous Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coal Worker's Pneumoconiosis</b> COAL WORKERS PNEUMOCONIOSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Coal Worker's Pneumoconiosis</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>10/18</b> , 19 <b>79</b> , to <b>11/8</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>11/8</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Patricia X. Stagg</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/9/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patricia X. Stagg</b>				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/14/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>LANDOVER MD.</b> COUNTY STATE				
24. FUNERAL DIRECTOR <b>K. HOFFMAN) HOFFMAN FUNERAL HOME 909-6</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia X. Stagg</b>				



W. J. B. 111

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 6 1

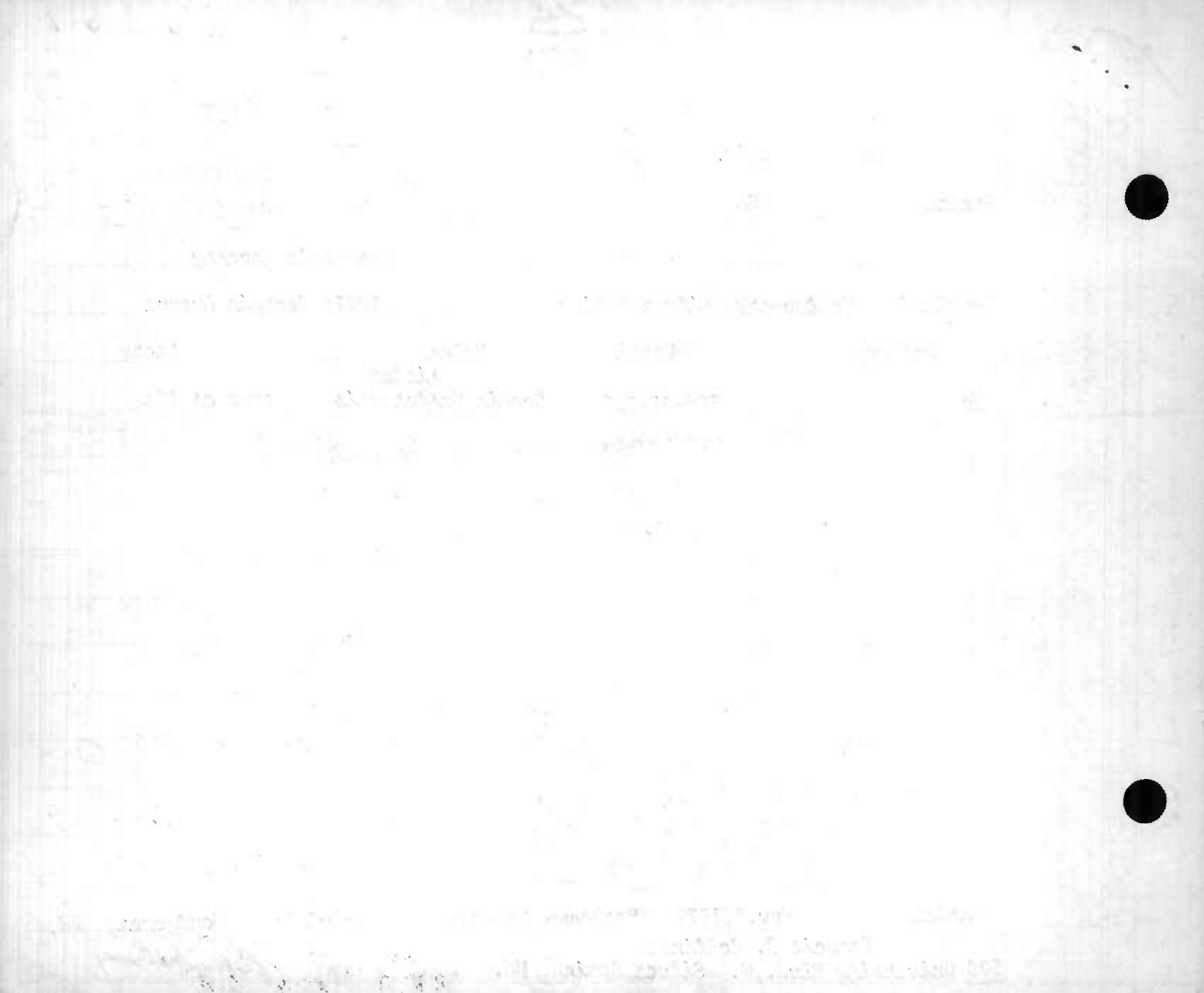
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William A Versis			2a. DATE OF DEATH MONTH DAY YEAR 1 11 4 79			2b. HOUR 6:40 PM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01 06 04		6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) wholesale grocery		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Versis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Leony				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-03-3270		17. INFORMANT sister ADDRESS same as 13c		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hour</u> <u>2 weeks</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>10/12</u> 19 <u>79</u> , to <u>11/4</u> 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>11/24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Morton W. Shapiro</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-4-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton W. Shapiro MD.		22e. ADDRESS 225 Pook Hill Rd Beth Md.	

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Nov. 7, 1979		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR NOV 8 1979		25b. REGISTRAR'S SIGNATURE <u>L. J. Helms</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Gustave VILLARET, JR.					2a. DATE OF DEATH MONTH DAY YEAR November 20 1979			2b. HOUR 1242P M		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR May 2 1892		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Army		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Virginia					13c. COUNTY Fairfax		13d. CITY OR TOWN McLean		13e. STREET ADDRESS 1050 Balls Hill Road	
14 FATHER'S NAME FIRST MIDDLE LAST Gustave Villaret					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Louise Armand					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1914-1952		17 INFORMANT Mrs. Frances G. Villaret		17 ADDRESS See item 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis secondary to peritoneal abscesses</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 21</u> 19 <u>79</u> , to <u>Nov. 20</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov. 20</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John N. Parker</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Nov. 21 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John N. Parker, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/23/79		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.				
24 FUNERAL DIRECTOR NAME C. M. Truett				ADDRESS Murphy Arlington Funeral Home, Arlington, Va.		25a. DATE REC'D. BY REGISTRAR NOV 26 1979		25b. REGISTRAR'S SIGNATURE <i>Henry M. Brady</i>		







Approped by Coroner, Dr. Bell 35  
00  
35

## MEDICAL CERTIFICATION

10

4300 BP.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-28569		
1- FOR STATE REGISTRAR										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Carl William Wagner					2a. DATE OF DEATH MONTH DAY YEAR Nov. 8, 1979					2b. HOUR Approx. Noon M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1911			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10519 Warfield St.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Plumber			12b. KIND OF BUSINESS OR INDUSTRY Plumbing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10519 Warfield St.				
14. FATHER'S NAME FIRST MIDDLE LAST William A. Wagner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Daymude							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-05-6566		17. INFORMANT 10518 Warfield Ave. Paul E. Wagner Kensington, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Approx 2 1/2 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hyper tension, Heart failure</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>December 1977</u> to <u>Nov. 8, 1979</u> , that (we) last saw the deceased alive on <u>October 9, 1979</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.												
22b. SIGNATURE <u>Joseph A. Romeo MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/9/79</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Romeo					22e. ADDRESS Bethesda, Md. 10401 Old Georgetown Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/10/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE <u>Robert A. Humphrey</u>					

79-28569

79-38207

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

NOV 19 1934

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.  
NOV 19 1934

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

100-38207-100

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #17 Film G537 11/30/79 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 7 0

FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry L. Wagner				2a. DATE OF DEATH MONTH DAY YEAR 11-11-79		2b. HOUR 908 P.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7-18-06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Textile	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. CITY OR TOWN Silver Spring		13c. STREET ADDRESS 12503 Bushey Drive	
14. FATHER'S NAME FIRST MIDDLE LAST John Wagner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl V. Shenholtz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Kaefer Wagner Anna B. Kaefer Silverspring, MD Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 79</u> to <u>11/11 19 79</u> , that (I) (we) lost saw the deceased alive on <u>Oct 19 79</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Garry N. Rosenbaum, M.D.</u>				DEGREE		22c. DATE SIGNED 11/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARRY N. ROSENBAUM				22e. ADDRESS 3720 Farnaght Ave Kensington, Md. 20785			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-15-79		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME Scarpelli R M.				ADDRESS		25a. DATE REC'D. BY REGISTRAR 11-15-79	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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WATERLOO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Malvine MIDDLE K. LAST Wallenstein		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
MALVINE K. WALLENSTEIN				11 12 79		1 P		M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		White		02 01 99		80 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Ohio		U.S.A.				MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSPITAL		Housewife		Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
13a. STATE		Montgomery Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4701 Willard Ave.			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Max Weiss		Nettie (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No		579-56-7915		Morton Garfield, 6002 Lavin La., Bethesda, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic CV Disease</u>								10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								15 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-1-1979 to 11-12-1979, that (I/we) lost above (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Bernard H. Ostrow MD						11-12-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
BERNARD H. OSTROW MD		5225 Pooks Hill Rd., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		11/14/1979		Wash. Hebrew Cong. Mem.		P.K. Washington, D.C.			
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons Inc.		5150 Wisconsin Ave. N.W. Wash. D.C.		NOV 19 1979		Lester McBratney			

Wendy, Md.

Wendy

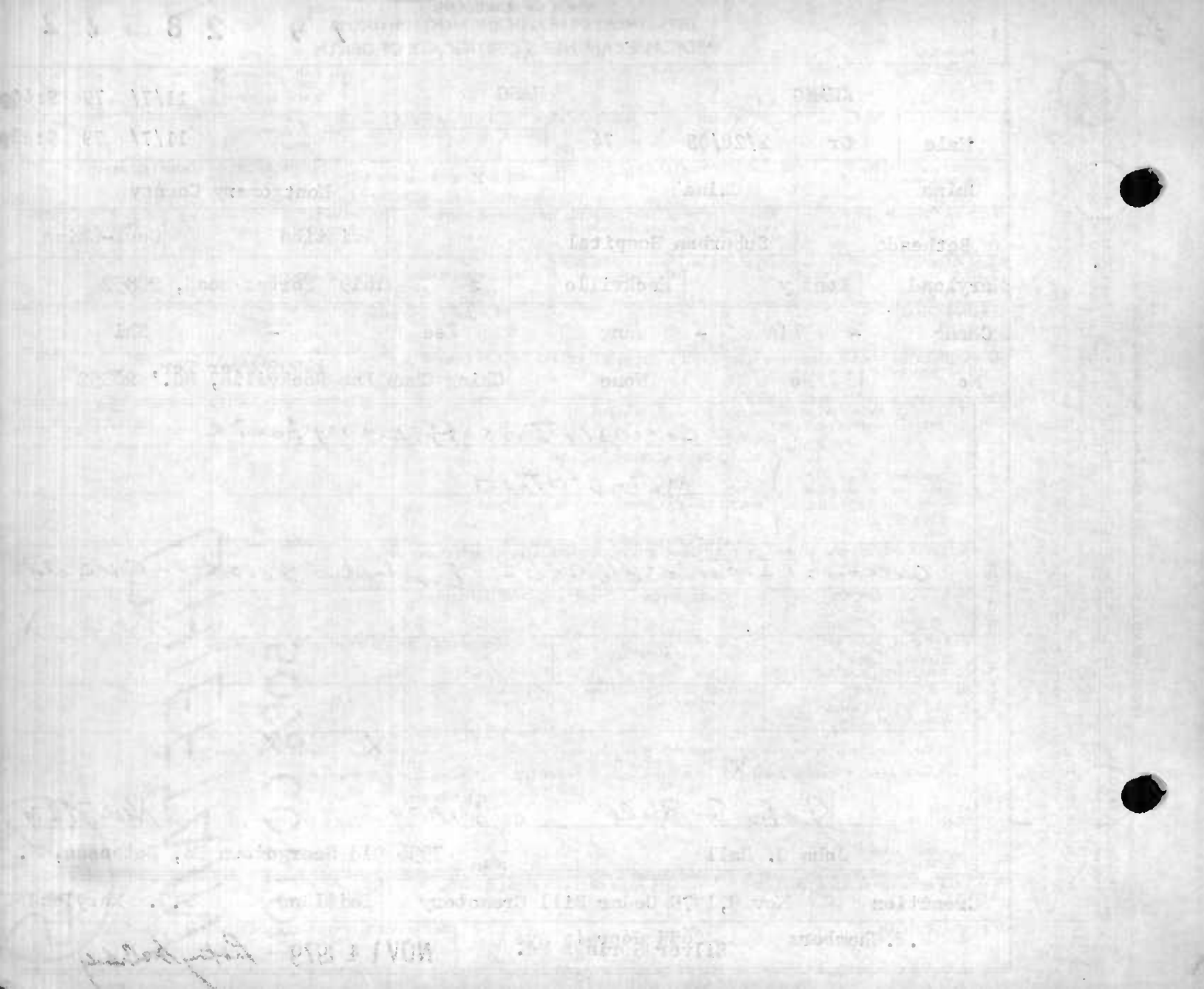


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST KWANG		MIDDLE		LAST WANG		2b. DATE KNOWN OF DEATH ESTIMATED		<input checked="" type="checkbox"/> MONTH 11/7/1979		2d. HOUR 9:47p	
3. SEX Male	4. RACE Or	5. DATE OF BIRTH MONTH 2/28/05 YEAR		6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH 11/7/1979		2d. HOUR 9:47p	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China		7b. CITIZEN OF WHAT COUNTRY? China		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aviation		12b. KIND OF BUSINESS OR INDUSTRY Govt-China					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Montgy		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1619 Forbes Road, 20852					
14. FATHER'S NAME FIRST Chang MIDDLE Lin LAST Wang				15. MOTHER'S MAIDEN NAME FIRST Lee MIDDLE Shi LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Ching Chun Lao 14202 Over Ter, Rockville, Md., 20852									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 2639 IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Malnutrition DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Cerebral Arteriosclerosis - Epileptic Seizures - CVA old													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED Nov. 7, 1979	
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS 7936 Old Georgetown Rd, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov 9, 1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY PREVIOUS Suitland		COUNTY STATE P.G. Maryland			
24. FUNERAL DIRECTOR NAME W.W. Chambers				ADDRESS 8655 Georgia Ave Silver Springs Md.				25a. DATE REC'D. BY REGISTRAR NOV 14 1979		25b. REGISTRAR'S SIGNATURE Ruthy McCalister			



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

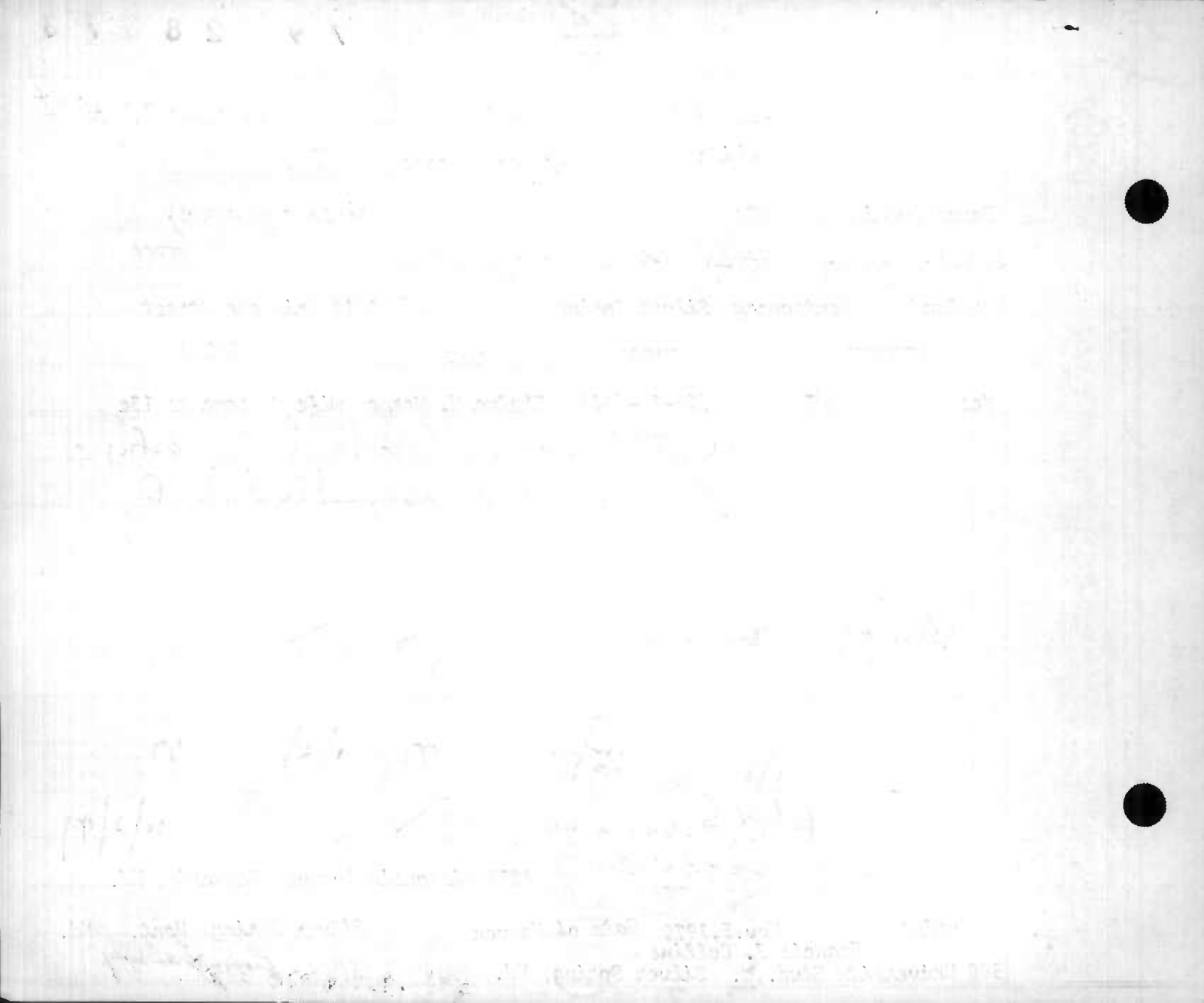
7 9 2 8 5 7 3

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George M. Wargo</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-2-79</b>			2b. HOUR <b>5:54 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 23 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>PEPCO</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>1918 Brisbane Street</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA HILLEN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI 579-10-4684</b>		17. INFORMANT ADDRESS <b>Thelma H. Wargo wife same as 13e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO OR AS A CONSEQUENCE OF (b) <b>Interruption of coronary artery blood flow</b> DUE TO OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>10/31/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal aortic aneurysm</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23/79</b> 19 <b>79</b> to <b>11/2/79</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11/1/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph H. Schanno MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/2/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH SCHANNO</b>				22e. ADDRESS <b>8218 Wisconsin Avenue Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>R. J. Schanno</b>			
500 University Blvd., W. Silver Spring, Md.									

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FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										9 28574 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lucy B. Washington										2a. DATE KNOWN OF DEATH ESTIMATED Nov. 29 1979										2b. HOUR 9:55 AM	
3. SEX F		4. RACE Blk		5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1890		6. AGE (IN YEARS) LAST BIRTHDAY 89 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD Nov 29 1979		7d. HOUR 8 M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD									
10. CITY OR TOWN OF DEATH Gleney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. Gen'l. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md				13b. COUNTY Mont.				13c. CITY OR TOWN Silago				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
14. FATHER'S NAME FIRST MIDDLE LAST Samuel BACON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine PRETTYMAN				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-32-9364									
17. INFORMANT ADDRESS SAME AS #13				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Malnutrition																					
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE George R. Snowden				TITLE (SPECIFY) M.D. Rego				MEDICAL EXAMINER				DATE SIGNED Nov 29 1979									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-3-79		23c. NAME OF CEMETERY OR CREMATORY Ash Mem. Cemetery				23d. LOCATION (CITY OR TOWN) COUNTY Sandy Spring Montg Md.											
24. FUNERAL DIRECTOR NAME George R. Snowden				ADDRESS 246 N. WASH. ST. Rockville, Md.				25a. DATE REC'D. BY REGISTRAR DEC 4 1979				25b. REGISTRAR'S SIGNATURE Loring McCreedy									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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11 12 13 14 15 16 17 18 19 20

21 22 23 24 25 26 27 28 29 30  
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91 92 93 94 95 96 97 98 99 100



100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

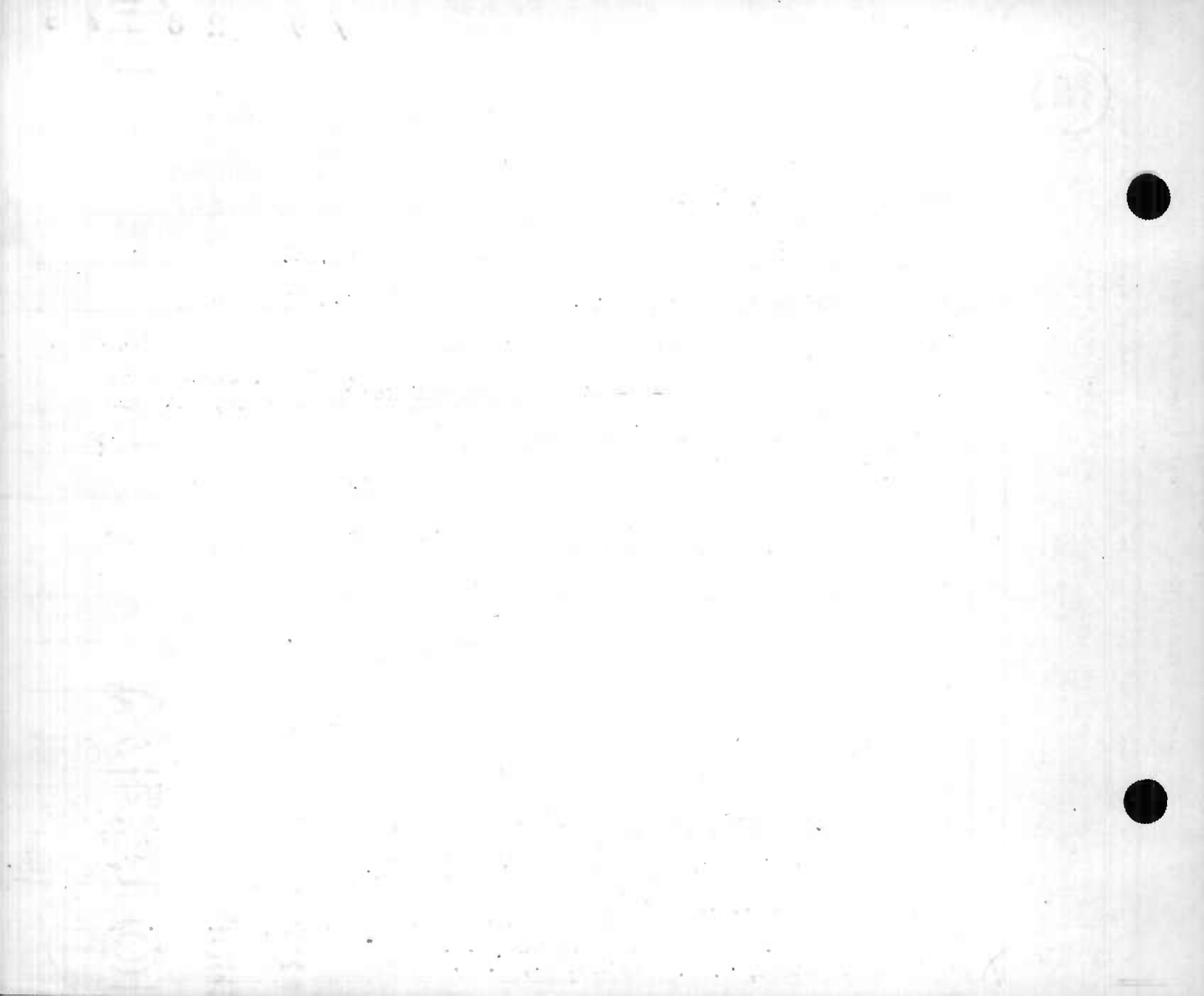
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA</b>			FIRST <b>WATTENBERG</b>			LAST			2a. DATE OF DEATH MONTH DAY YEAR <b>11 10 79</b>			2b. HOUR <b>4<sup>05</sup> AM</b>		
3 SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>June 27, 1895</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>8715 First Avenue</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Bernstein</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie (Unknown)</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>065-14-21070</b>			17 INFORMANT ADDRESS <b>Leonard Wattenberg 7508 Granada Drive Bethesda, Maryland</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 HRS</b>		
4149 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b>												5 YRS		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b>												5 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 noon 11/9 79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11125 ROCKVILLE PIKE ROCKVILLE, MD</b>								
22a. I certify that (I) (this hospital) attended the deceased from <b>11/9 79</b> to <b>11/10 79</b> , that (I) (we) lost <b>11/9 79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.														
22b. SIGNATURE <b>Roger Stevenson MD</b>						DEGREE <b>MD</b>						22c. DATE SIGNED <b>11/10/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER STEVENSON, JR MD</b>						22e. ADDRESS <b>11125 ROCKVILLE PIKE ROCKVILLE, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/11/1979</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mount Lebanon Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi, Pr. Geo. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Donald M. Stein Hebrew Memorial F.H.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1979</b>								
23e. REGISTRAR'S SIGNATURE <b>232 Carroll Street, N. W. Washington, D. C.</b>						25b. REGISTRAR'S SIGNATURE <b>History/Registry</b>								





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELMER R. WEAVER			2a. DATE OF DEATH MONTH DAY YEAR Nov. 3, 1979		2b. HOUR 11:55 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 5, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Col.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Beth. Retirement & Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist	12b. KIND OF BUSINESS OR INDUSTRY B. of Standards	
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. STREET ADDRESS 8700 Jones Mill Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST David Weaver		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melinda --- Rupel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 220-46-0252		17. INFORMANT ADDRESS 6816 Delaware St. Mrs. Gertrude S. Augustine C.C. Md.	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i> 5900 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Pyelonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Cerebral Vascular Accident - Right Hemiplegia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>November 3, 1977</i> , to <i>November 3, 1979</i> , that (I) <del>(was)</del> last saw the deceased alive on <i>October 31, 1979</i> , and that in (my) <del>(best)</del> opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death)					
22b. SIGNATURE <i>Blaine Fitzgerald</i>		DEGREE M.D.		22c. DATE SIGNED 11/3/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.		22e. ADDRESS 8218 Wisconsin Ave. Bethesda			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation		23b. DATE 11/5/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR NOV 07 1979 25b. REGISTRAR'S SIGNATURE <i>Harry H. Brady</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

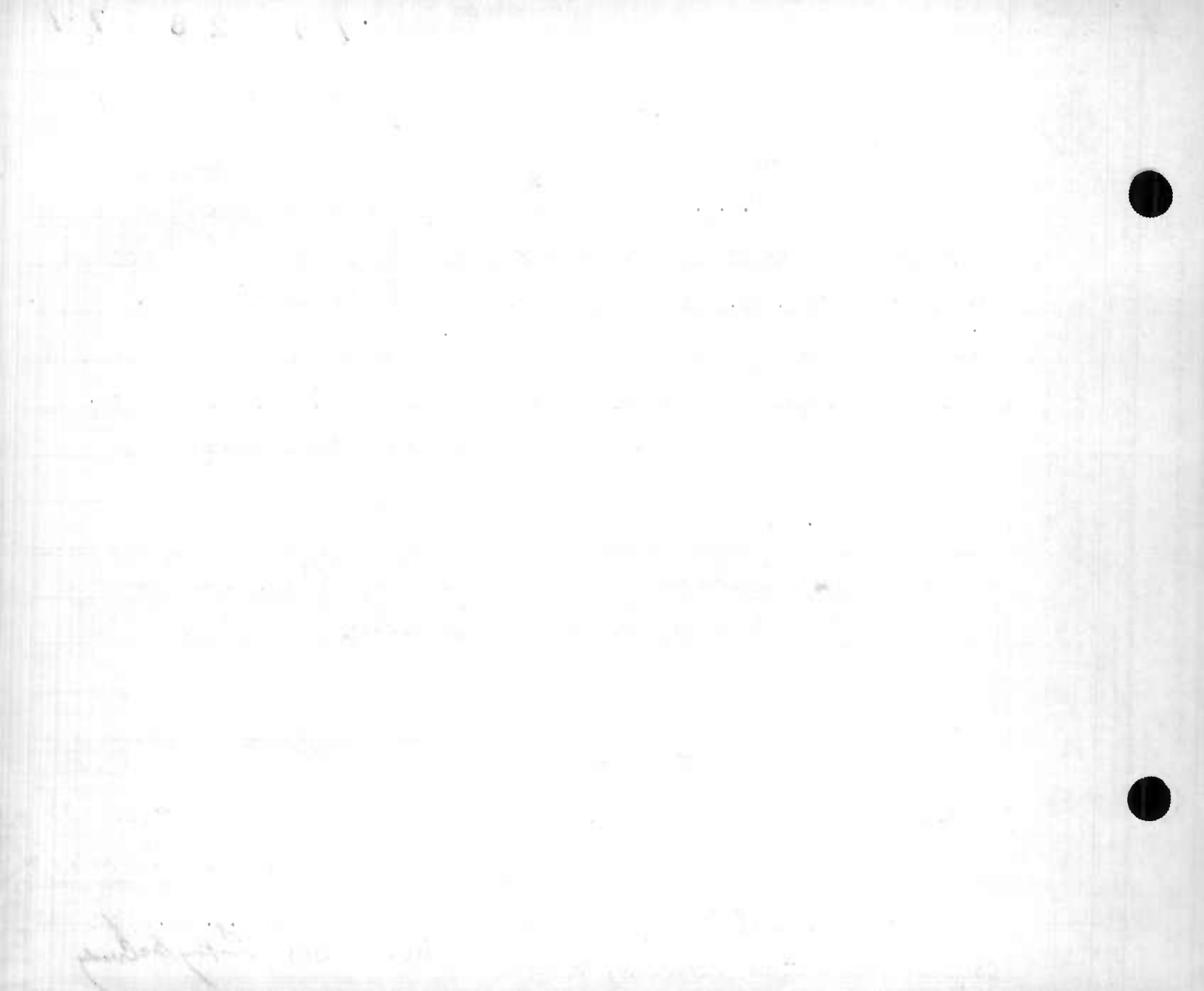


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>ALEXANDER WEINSTEIN</u>				11 6 79 9:35 P.M.			
3 SEX <u>Male</u>		4 RACE <u>white</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>1 21 1897</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Russia</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.	
10 CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Professor</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
13a STATE <u>Maryland</u>		13b COUNTY <u>Mont. Co.</u>		13c CITY OR TOWN <u>Silver Spring</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>Julius - Weinstein</u>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>(Unknown)</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO <u>555-44-9769</u>		17 INFORMANT ADDRESS <u>Marianne Weinstein (Wife) Same as # 13.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular insufficiency</u> 4379 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Benign Prostatic Hyperplasia, Emphysema</u>							
19a DATE OF OPERATION <u>9-14-79</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Benign Prostatic Hyperplasia</u>		19c AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>Nov 6</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov 5</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Henry M. Wise, Jr.</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>9 Nov 79</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>HENRY M WISE, JR.</u>		22e ADDRESS <u>1111 SPRING ST, SILVER SPRING MD</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b DATE <u>Nov/9/79</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, P.G. Co., Maryland</u>	
24 FUNERAL DIRECTOR NAME <u>Chambers Funeral Home</u>		ADDRESS <u>Riverdale, Maryland</u>		25a DATE RECEIVED BY REGISTRAR <u>NOV 14 1979</u>		25b REGISTRAR'S SIGNATURE <u>Henry M. Wise, Jr.</u>	



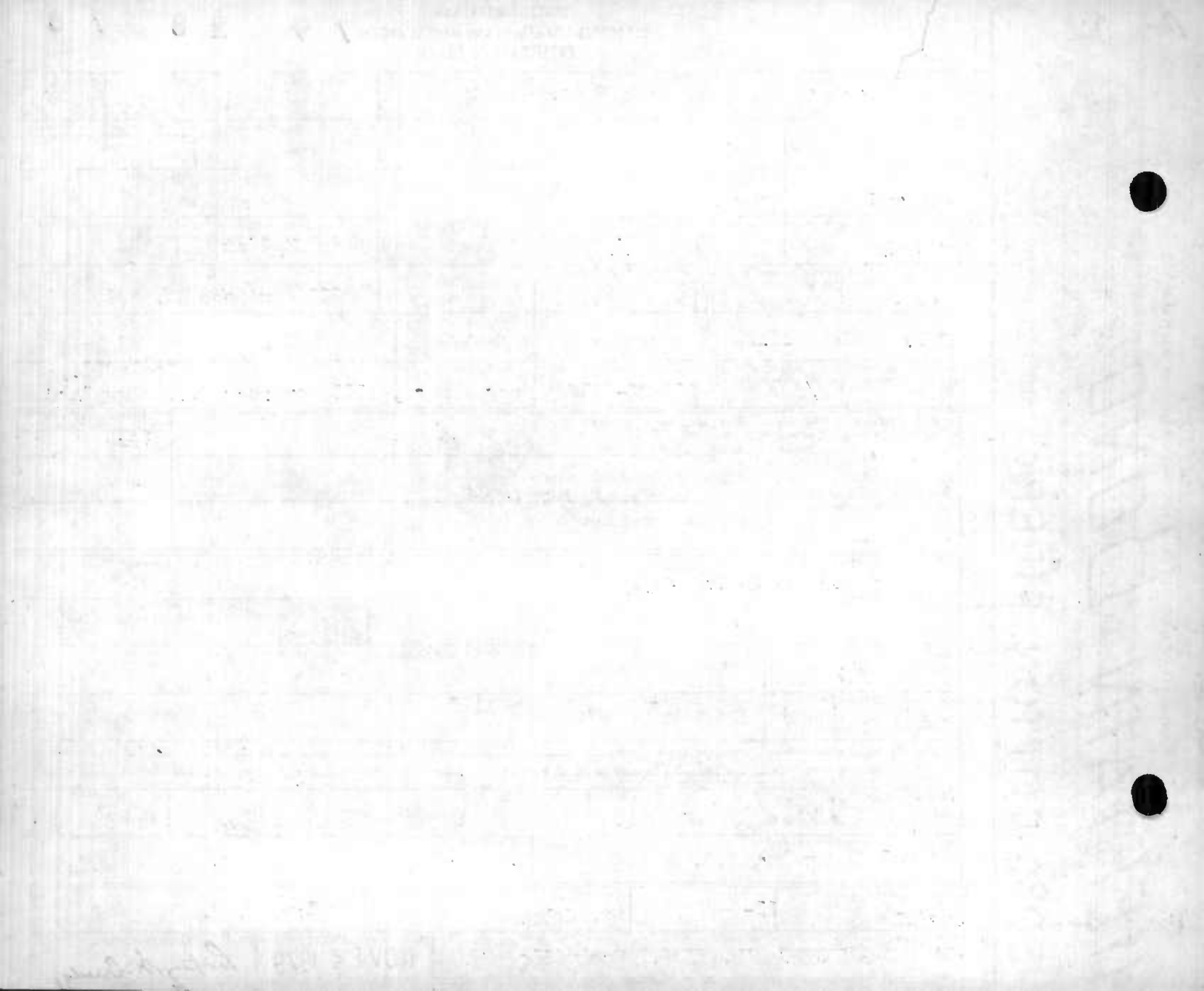
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Ethel</b>		2a. DATE OF DEATH MONTH <b>Nov.</b> DAY <b>6</b> YEAR <b>79</b>	
3. SEX <b>F</b>		2b. HOUR <b>3<sup>55</sup> A.M.</b>	
4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>25</b> YEAR <b>04</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hair Stylist</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Hair</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>	
13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Elias</b> MIDDLE <b>----</b> LAST <b>Werner</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Sophie</b> MIDDLE <b>----</b> LAST <b>Weinberg</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>086-03-9613A</b>	
17. INFORMANT <b>Anna Werner</b>		ADDRESS <b>6111 Montrose Ave., Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>4275-</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>chronic</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-8</b> , 19 <b>78</b> , to <b>11-6</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>11-5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b. SIGNATURE <b>Carol L. Bender</b>		22c. DATE SIGNED <b>11-6-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carol L. Bender, M.D.</b>		22e. ADDRESS <b>1125 Rockville Pk., Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-8-79</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>		23d. LOCATION CITY OR TOWN <b>Isett, N. J.</b> COUNTY STATE	
24. FUNERAL DIRECTOR <b>DANZANSKY-GOLDBERG MEM. CHAP.,</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1979</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>P. J. K. Bender</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) John C. WEST					2a. DATE OF DEATH November 19 1979			2b. HOUR 11:50 P <sup>M</sup>		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH March 22 1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia					13b. COUNTY Arlington		13c. CITY OR TOWN Arlington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur L. West					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adell Marlar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1931-54		17. INFORMANT Mrs. Mary Ellen West		ADDRESS See item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Emphyema</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I (this hospital) attended the deceased from <u>Nov. 18</u> 19 <u>79</u> to <u>Nov. 19</u> 19 <u>79</u> , that (I (we) lost saw the deceased alive on <u>Nov. 19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.										
22b. SIGNATURE <u>Mark Browning</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED Nov. 20, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Browning, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/23/79		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.				
24. FUNERAL DIRECTOR NAME <u>George L. Brown</u>				ADDRESS Arlington Funeral Home Arlington, Va.		25a. DATE OF REGISTRATION NOV 28 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



11/23/11

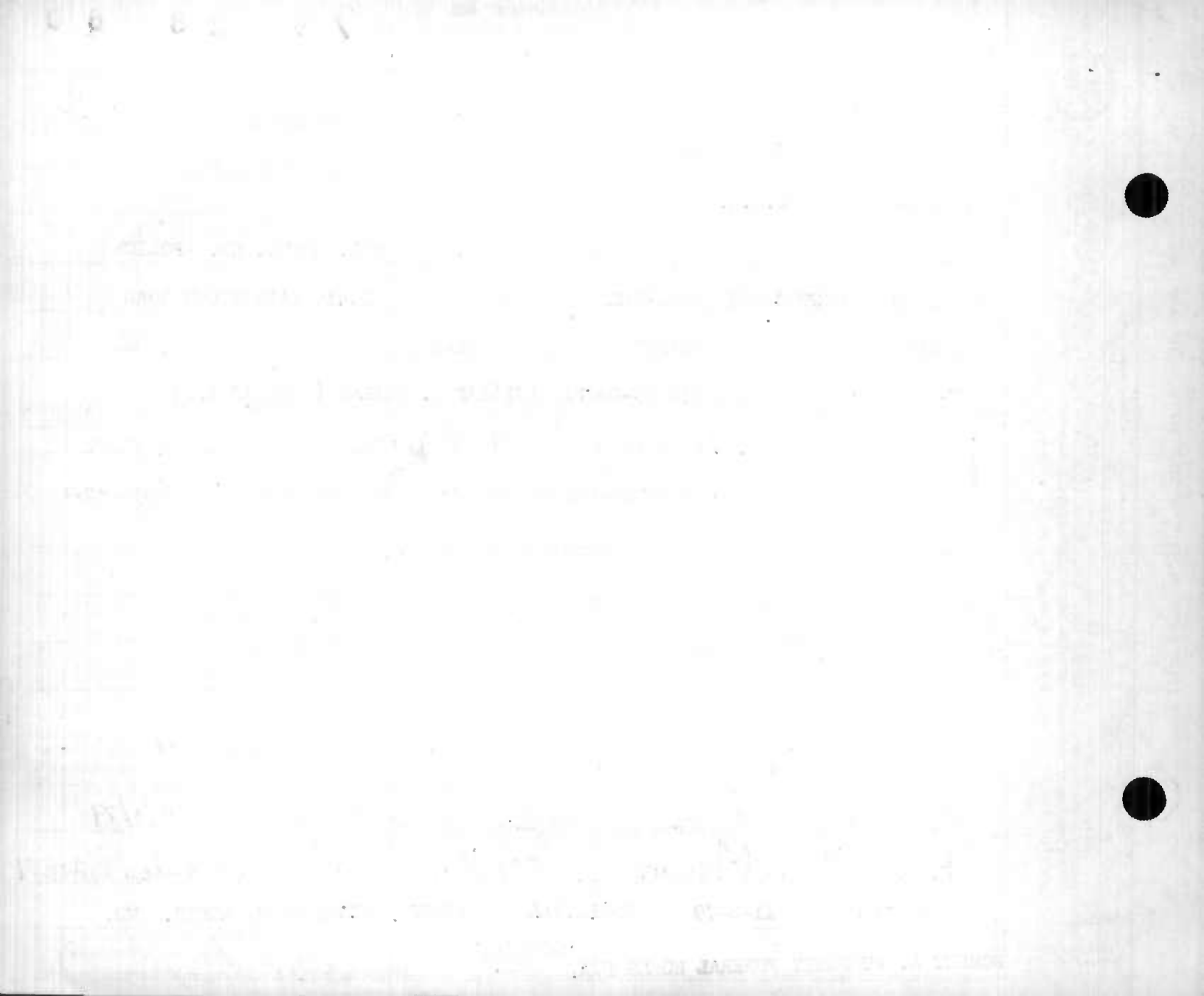
Chickadee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 2 8 5 8 0						
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
Lloyd M. Whalen			11/5/79			6:36 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
Male		CAUCASIAN		9/16/15		64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		Suburban Hospital				RET. MONTG. CO.		POLICE	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
MARYLAND			MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS			
OSCAR			GRACE			10416 DARNESTOWN ROAD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO			578-09-0428A		LILLIAN M. WHALEN (SAME AS 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Congestive Heart Failure									2 years
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease									5 years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR						
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION				
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 11/5/79 to 11/5/79, that (I) (we) lost saw the deceased alive on 11/5/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.)									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Robert C. Macon					M.D.			11/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Robert C. Macon					809 Viers Mill Rd. Rockville Md 20851				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL			11-8-79		NEELSVILLE CEMETERY		GERMANTOWN COUNTY MD.		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY FUNERAL HOMES P/A					NOV 19 1979		[Signature]		



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>Emily Pearl Wheelless</i>			2a DATE OF DEATH MONTH DAY YEAR <i>11/1/79</i>			2b HOUR <i>9 P M</i>			
3 SEX <i>female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 27, 1890</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Texas</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a STATE <i>Maryland</i>		13b. COUNTY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>6721 Chillum Manor Road</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>William Henry Martin</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jane Jackson</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-56-0516</i>		17 INFORMANT <i>daughter</i>		ADDRESS <i>same as 13e</i>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>4286</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CVA</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHF</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i> <i>2 1/2 wks</i> <i>2 1/2 wks</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>10-14</i> , 19 <i>79</i> , to <i>11-1</i> , 19 <i>79</i> , that (1) (we) last saw the deceased alive on <i>11-1</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.H. Sanderstrom</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-2-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.H. Sanderstrom</i>				22e. ADDRESS <i>7781 Carroll Ave Trk 04, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 6, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>			
24 FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 8 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert Halverson</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be performed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Jan. 27, 1992

USA

Texas

Montgomery

X

Harwood

Texas Tech

6781 Clifton Ranch Road

Harwood

Harwood

Harwood

Jan

Harwood

Harwood

Harwood

daughter

born in 1960

212-55-2514

Harwood

Silver Spring, Md.

Jan. 1, 1992

Harwood

Harwood, Md. Silver Spring, Md.

## MEDICAL CERTIFICATION

DHMH - 17  
(VR A15 ME (5))  
30M 7/73





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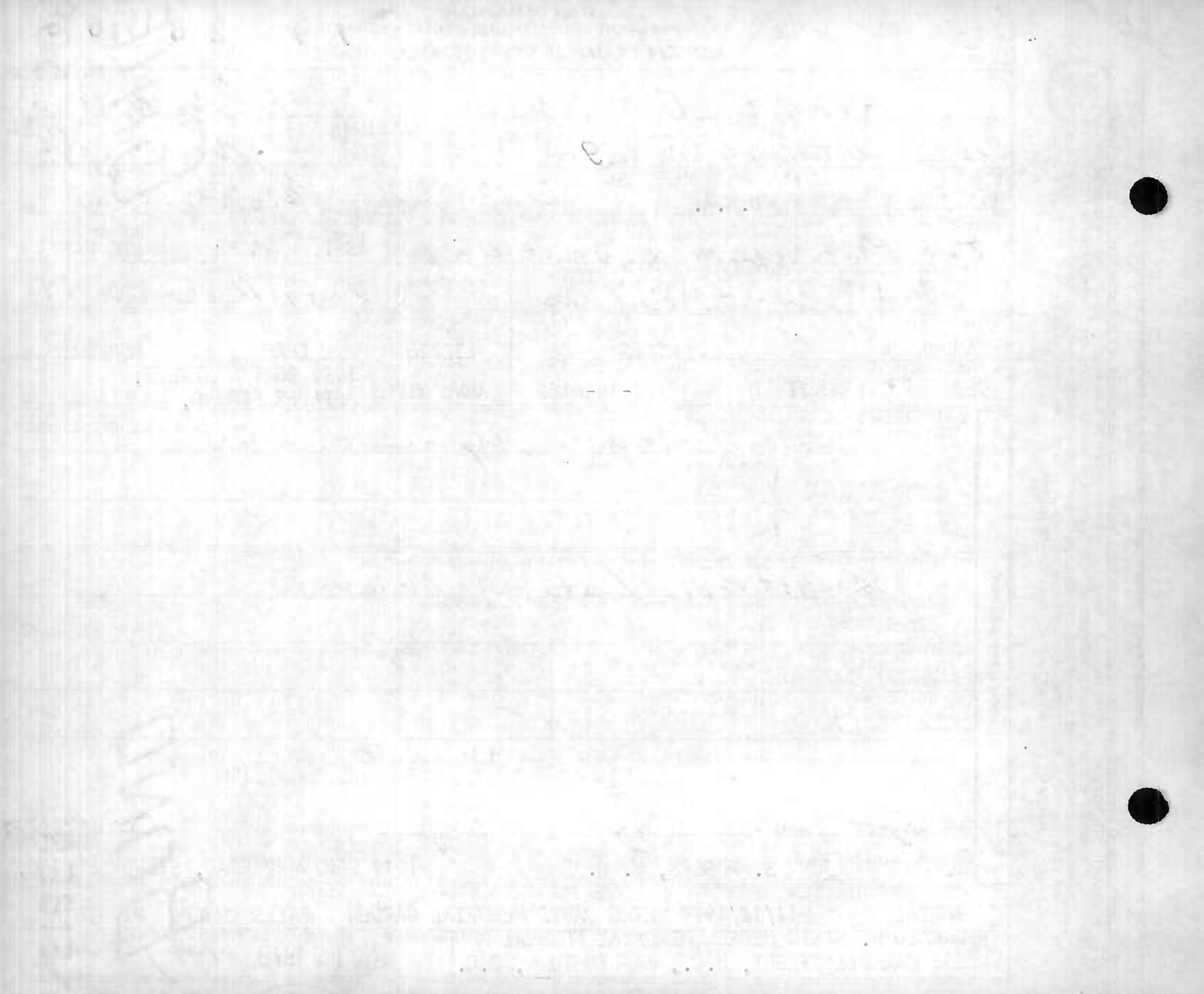
NOV 21 1957

NOV 21 1957

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28583																			
1. DECEASED NAME (TYPE OR PRINT) <b>Robert DAVID Wides</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>Nov 14, 1979</b>										2b. HOUR <b>11:02 AM</b>																													
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 4 1919</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>59 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD <b>Nov 15, 1979</b>										2d. HOUR <b>11:12 AM</b>																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>										7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.																			
10. CITY OR TOWN OF DEATH <b>Tak Park</b>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Advent Hosp</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ASST. MANAGER</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>AUTO PARTS</b>																			
13a. STATE <b>Md</b>										13b. COUNTY <b>Mont</b>										13c. CITY OR TOWN <b>Sping</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>1059 Rutan St.</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL WIDES</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LIZZIE LEAH BORKON</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>										16b. SOCIAL SECURITY NO. <b>142-10-6125</b>										17. INFORMANT <b>ANNE WIDES</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b> <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Angiotropic Latent Sclerosis</b>																													
19a. DATE OF OPERATION <b>None</b>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held on										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.										TITLE (SPECIFY) <b>Medical Examiner</b>										DATE SIGNED <b>Oct 14 1979</b> <b>MARYLAND</b>																													
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS, M. D.</b>										ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING,</b>																																							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>										23b. DATE <b>11/18/1979</b>										23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>FALLS CHURCH VIRGINIA</b>																			
24. FUNERAL HOME <b>DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>										25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>										25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>																													
NAME <b>232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>										ADDRESS																																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Harold Allen Williams			November		4		1979		205P		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Caucasian		May 2 1915		64		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		USA				Montgomery						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		National Naval Medical Center		U. S. Army									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Harford		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		529 Windemere Drive					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Orval Allen Williams		Margaret A. Berry											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		153 18 5051		Mrs. Rosemary Williams		See item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Acute myocardial infarction complicated</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF <u>by bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 25</u> 19 <u>79</u> , to <u>Nov. 4</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Nov. 4</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>William H. Davis MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED Nov. 5, 1979					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS National Naval Medical Center, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/9/1979		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Princeton Mercer West VA					
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A. Aberdeen, Md. 21001		ADDRESS				25a. DATE REC'D BY REGISTRAR NOV 08 1979		25b. REGISTRAR'S SIGNATURE <u>Walter H. Brady</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					7 9 2 8 5 8 5				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
James R. Wines					November 11, 1979				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		Caucasian		Nov. 27 1894		84 YRS		6:20am	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital		Farmer		Farmer			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?				
13a. STATE: Virginia 13a. COUNTY: Fauquier 13c. CITY OR TOWN: Upperville					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
William Masters Wines					Mary Anna Brady				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		223-36-7315		Bayla Gardens 8 N. Summit Ave. Mrs. Constance Peters Gaithersburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septic Shock</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1519 } DUE TO, OR AS A CONSEQUENCE OF <u>anemia</u> <u>Hypovolemia</u>								24 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF <u>metastatic carcinoma from stomach</u>								1 month	
(c) <u>metastatic carcinoma from stomach</u>								7 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ASHD</u> <u>CHF</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> , 19 <u>79</u> , to <u>11/11</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) <u>sign the body after death</u>									
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Gregorio Koss</u>				<u>DR. PASQUAL PERINO</u>				11/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
<u>GREGORIO KOSS</u>				<u>13 E. DEER PARK DR. GAITHERSBURG MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE	
Burial		Nov. 14, '79		Leed's Cemetery		Hume		Fauquier Virginia	
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTERED			
Gartner-Sandison F. H. Gaithersburg, Md.				316 E. Diamond Ave. NOV 15 1979					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 8 5 8 6			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby R. Winslow				2a. DATE OF DEATH MONTH DAY YEAR November 15, 1979		2b. HOUR A 6:45 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec 3 1899		6. AGE (IN YEARS LAST BIRTHDAY) 79 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Friends Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt.		12b. KIND OF BUSINESS OR INDUSTRY IRS Ret.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Sandy Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 17340 Quaker Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Colonel Randolph Rogers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Page			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT 6289 DORRIS Joan W. Ostrosky		Clarksville, Md. 21029	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension coma</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CVA + marked dehydration</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> , 19 <u>79</u> , to <u>11-14</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Michael A. Bolognese M.D.</u>				DEGREE M.D.		22c. DATE SIGNED 11/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. BOLOGNESE, M.D.				22e. ADDRESS 19261 MONTGOMERY VILLAGE AVE. GAITHERSBURG, Md 20760			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 18, 79		23c. NAME OF CEMETERY OR CREMATORY Cedardale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mullins, South Carolina	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR NOV 19 1979		25b. REGISTRAR'S SIGNATURE R. J. McBrady	
11800 New Hampshire Ave., Silver Spring, Md.							

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NOV 10 1941

COMMUNICATIONS SECTION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 2 8 5 8 7	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Seigfried Roland Witt</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 27 19 79</b>			2b. HOUR <b>12:45 P.M.</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>dec. 2 1940</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD <b>11 27 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>19034 Canadian Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCT.EX., STOCKBROKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Finance</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>19034 CANADIAN COURT</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK P. WITT</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>THALIA HINCHEE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>VIETNAM-USMC 230-54-5295</b>		17. INFORMANT ADDRESS <b>SHARRON M. WITT (SAME AS 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination and drowning</b> <b>956-</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Noon P.M. 11/27 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted wounds in bathtub of full</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>19034 Canadian Ct, Gaithersburg, Mont Co., MD</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H.R. Shaw</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>11/28/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>11-30-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY MEM. GARDENS</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHARLOTTESVILLE VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>ROCKVILLE MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	

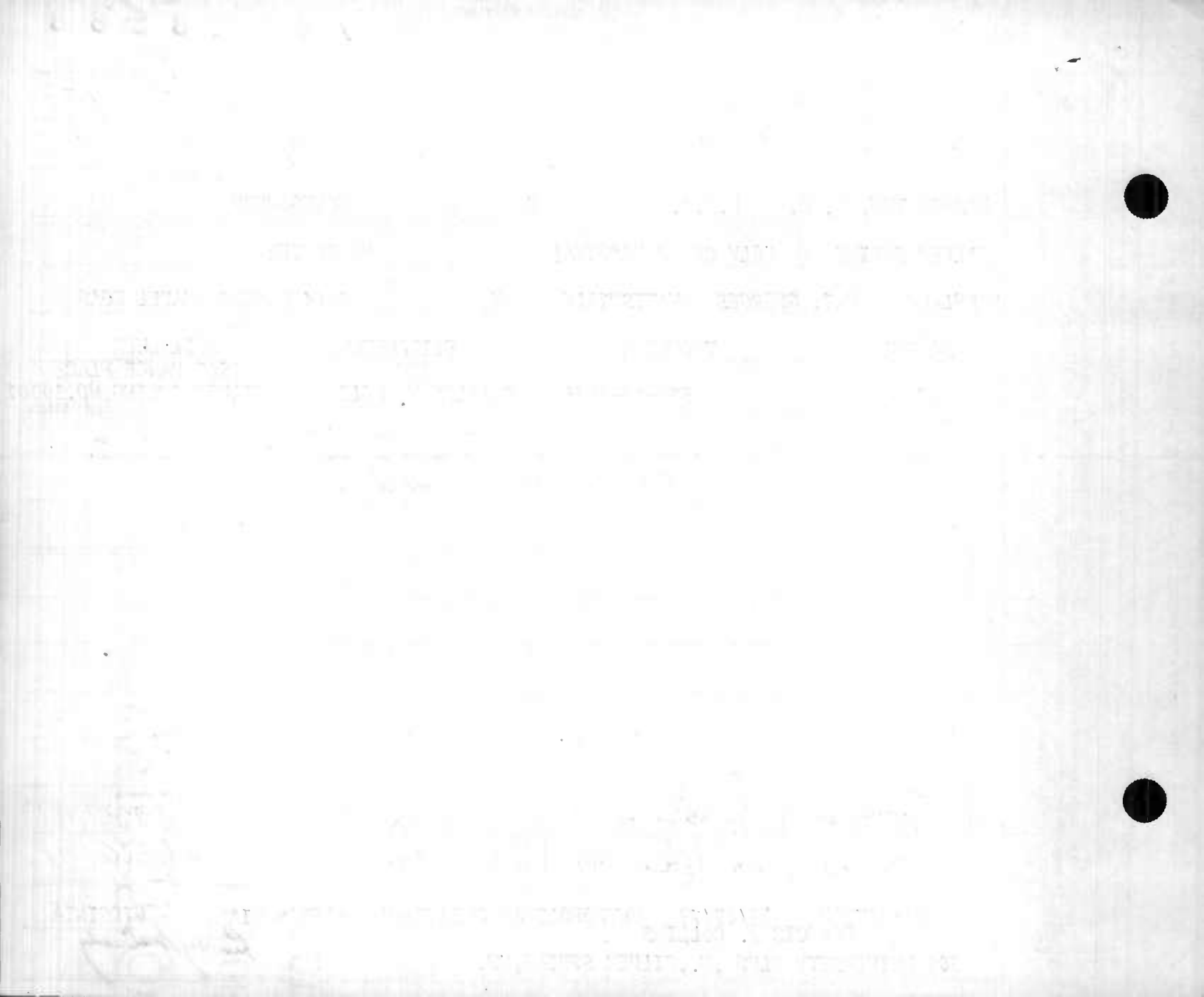


TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE M. WOLZ</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11/26/79</b>		2b. HOUR <b>1:40</b> P.M.			
3. SEX <b>female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10/02/58</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>21</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>PRI. GEORGES</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL THOMPSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH WEILACHER</b>		13r. STREET ADDRESS <b>5604 QUEENS CHAPEL ROAD</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-26-0989</b>		17. INFORMANT <b>SON</b>		ADDRESS <b>9507 VANCE PLACE SILVER SPRING, MD. 20901</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory Arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Atherosclerotic Heart disease</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 26</b> 19 <b>79</b> , to <b>Nov 26</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Nov 26</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did (I) did not) view the body after death.									
22b. SIGNATURE <b>Howard S. Goldstein</b> MD				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>Nov 27, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Howard S. Goldstein MD</b>				22e. ADDRESS <b>4701 Randolph Rd, Rockville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>11/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ALEXANDRIA VIRGINIA</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				24b. ADDRESS <b>500 UNIVERSITY BLVD., W., SILVER SPRING, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 8 5 8 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST FLORENCE MIDDLE FLORENCE LAST WOODWARD WOODWARD		2a. DATE OF DEATH MONTH DAY YEAR Nov 4, 1979		2b. HOUR 10:56 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 21 1879	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST Francis MIDDLE Granger LAST Woodward		15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Ann LAST Ward		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 277-20-7663		17. INFORMANT ADDRESS Mrs John P. Dickson, Niece. Same as item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE 436- DUE TO, OR AS A CONSEQUENCE OF: (b) ARTERIOSCLEROTIC CEREBRO DUE TO, OR AS A CONSEQUENCE OF: (c) VASCULAR DISEASE 2 YRS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (we) attended the deceased from 8 AUG 19 78 to 4 NOV 19 79, that (we) lost saw the deceased alive on 26 OCT 19 79, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Walter E. Goetz MD				22c. DATE SIGNED 4 NOV 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/7/1979		23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Cleveland Ohio		24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR NOV 07 1979	
25b. REGISTRAR'S SIGNATURE Lester M. Brady					

59  
90  
35  
158  
7

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

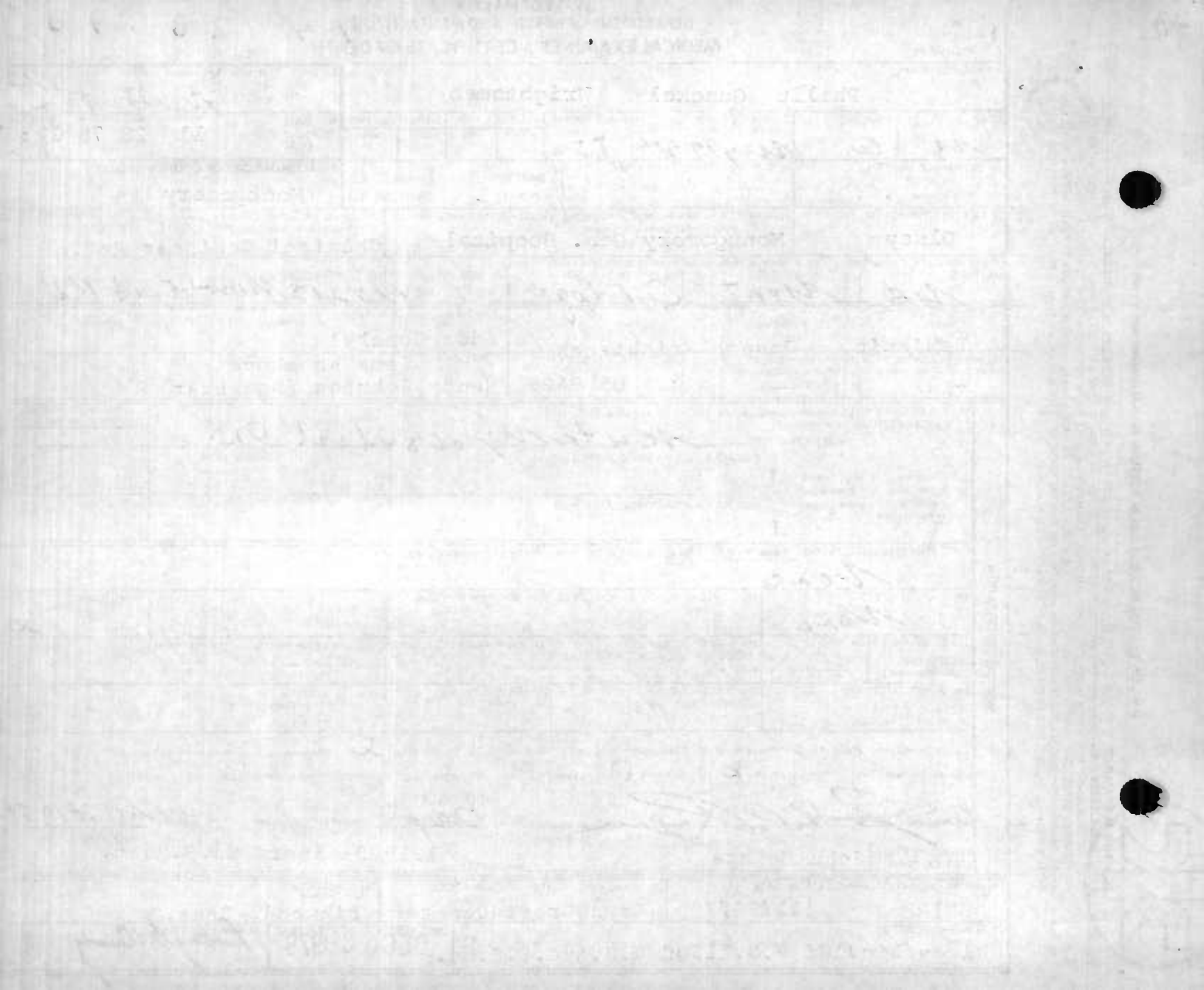




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28590	
1. FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <b>Philip Gunckel Wrightsman</b>										7b. DATE KNOWN OF DEATH <b>Nov. 28 1979</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>11/24/1954</b>		6. AGE (IN YEARS) <b>25</b>		7c. DATE PRONOUNCED DEAD <b>11 28 79</b>		7d. HOUR <b>12:00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemical Engineer Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>				13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>W. J. Spg.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (TYPE OR PRINT) <b>Benjamin Joseph Wrightsman</b>				15. MOTHER'S MAIDEN NAME <b>Adda Gunckel</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>221 05 9429</b>	
16c. (IF YES, GIVE WAR OR DATES) <b>WWI</b>				17. INFORMANT <b>Same as above</b>				17. INFORMANT <b>Nancy Johnson (Daughter)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
<b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Rogers</b>				TITLE (SPECIFY) <b>Dep.</b>				DATE SIGNED <b>Nov 28 1979</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Rogers</b>				ADDRESS <b>1919 Seminary Rd. S.S. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>11/30/79</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Lawn Croft Cemetery</b>			
23d. LOCATION CITY OR TOWN <b>Linwood, Penn.</b>				23e. COUNTY <b>Penn.</b>				23f. STATE			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b>				ADDRESS <b>F.H. 11800 N.H. Ave. S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1979</b>			
25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>											



Q HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28591

1 DECEASED NAME (TYPE OR PRINT) <b>MARIE C. WROBEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOVEMBER 14 79</b>			2b. HOUR MIN. <b>1255A</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>MARCH 15, 1915</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>12 55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2204 MUSGROVE ROAD</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE LONG</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHERINE MAE SPAVIN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-07-0271</b>		17 INFORMANT ADDRESS <b>RUDOLPH O. WROBEL SAME AS 13 HUSBAND</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b> <b>4329</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CARDIAC ARRHYTHMIA</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> 19 <b>79</b> to <b>11/13</b> 19 <b>79</b> , that (I) (we) lost the deceased alive on <b>11/13</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William R. Leahy</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/14/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William R. Leahy</b>					22e. ADDRESS <b>9811 Malcolm Dr Laurel Md 20811</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>		
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>		
25c. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>									

MEDICAL CERTIFICATION

1402

NO. 1  
 GEORGE  
 LONG  
 KATHERINE  
 WIFE  
 SPAIN  
 2001 HIGGINS ROAD  
 MONTGOMERY  
 SILVER SPRING MD  
 WASHINGTON VOLUNTARY HOSPITAL  
 HOUSEWIFE  
 NEW YORK  
 L.I.A.  
 WHITE  
 MARCH 15, 1915  
 MONTGOMERY  
 BORN IN 1904



SERIAL 11/17/76  
 FRANCIS J. COLLINS  
 500 UNIT, 2ND FLOOR, SILVER SPRING, MD. 20910  
 GATE OF HEAVEN  
 SILVER SPRING  
 MONT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
7 9 2 8 5 9 2									
1. FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Albert Isadore Yeroshefsky</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>November 21, 1979</b>		2b. HOUR <b>3:30 P.M.</b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>June 7, 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Clinical Center, NIH</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BAKER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>DONUT SHOP</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>PR. GEORGES</b>		13c CITY OR TOWN <b>Hyattsville</b>		13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>6003 Riggs Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES VEROSHEFSKY</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNY BECKER</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17 INFORMANT ADDRESS <b>Mr. Jerry Morris brother Same as above</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1729</b> IMMEDIATE CAUSE (a) <b>Respiratory failure, secondary to extensive infiltration of the lungs by metastatic tumor</b> DUE TO, OR AS A CONSEQUENCE OF b) <b>Metastatic melanoma with generalized involvement of the internal organs.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5 June</b> 19 <b>78</b> to <b>21 November 79</b> , <input checked="" type="checkbox"/> last saw the deceased alive on <b>21 November 79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b SIGNATURE <b>Eric H. Westin</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED <b>11/22/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eric H. Westin</b>				22e ADDRESS <b>The Clinical Center, National Institutes of Health, Beth., Md. 20205</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>11/26/1979</b>		23c NAME OF CEMETERY OR CREMATORY <b>MARYLAND VETERAN'S CEMETERY</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>CHELTHENHAM, PR. GEO. MD.</b>			
24 FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25a DATE RECD. BY REGISTRAR <b>NOV 27 1979</b>		25b REGISTRAR'S SIGNATURE			
232 CARROLL STREET, N. W., WASHINGTON, D. C.									





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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			7 9 2 8 5 9 3 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>Carl G. YOUNGERMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 15, 1979</b>				2b. HOUR <b>1:10A M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 22, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co., MD.</b>				
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Landscaper</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Boysds</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>20315 Bucklodge Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Youngerman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Winner</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-12-4782</b>		17. INFORMANT ADDRESS <b>Lucille H. Youngerman, Item 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Chronic Obstructive Pulmonary Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Decomodal of the Bladder: Proxylergic Carcinoma</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>10 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Decomodal of the Bladder: Proxylergic Carcinoma</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>5/12</b> , 19 <b>66</b> , to <b>11/15</b> , 19 <b>79</b> , that (I) (we) lost <b>11/14</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <b>and</b> (did not) view the body after death.										
22b. SIGNATURE <b>Robert C. Macon</b>				22c. DEGREE <b>M.D.</b>				22d. DATE SIGNED <b>11/15/79</b>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert C. Macon</b>				22f. ADDRESS <b>809 Viers Mill Rd. Rockville, Md 20851</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 17, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boysds Presbyterian</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boysds, Montgomery, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, Damascus, Md.</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 19 1979</b>						

